**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit. www.shpnc.gov. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms click on the term for more information. You can also view more information regarding this plan at www.shpnc.gov or call the Aetna Health Concierge Team at 833-690-1037.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$5,000** Individual/**$10,000** Family for in-network; **$10,000** Individual / **$20,000** Family for out-of-network; doesn't apply to in-network preventive care. Coinsurance and copayments do not apply to the deductible. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **What is the out-of-pocket limit for this plan?** | Yes. **$6,450** Individual/**$12,900** Family for in-network medical and pharmacy; **$12,900** Individual /**$25,800** Family for out-of-network | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Your cost for services when pre-authorization was not obtained, premiums, balance-billed charges and health care services this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit.** |

(DT - OMB control number: 1545-0047/Expiration Date: 01/31/2026) (DOL - OMB control number: 1210-0147/Expiration date: 09/30/2028) (HHS - OMB control number: 0938-1146/Expiration date: 05/31/2026)

| | | |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers** out-of-network **provider** for some services. |
| **Do you need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 50% coinsurance after deductible | 60% coinsurance after deductible | ——————none—————— |
| | Specialist visit | 50% coinsurance after deductible | 60% coinsurance after deductible | ——————none—————— |
| | Other practitioner office visit | 50% coinsurance after deductible | 60% coinsurance after deductible | Chiropractic care (up to 30 visits per benefit period) |
| | Preventive care/screening/ immunization | $0/visit | 60% coinsurance | The **deductible** does not apply to in-network provider services. |
| **If you have a test** | Diagnostic test (X-ray, blood work) | 50% coinsurance after deductible | 60% coinsurance after deductible | No coverage for tests not ordered by a doctor. |
| | Imaging (CT/PET scans, MRIs) | 50% coinsurance after deductible | 60% coinsurance after deductible | Prior authorization may be required, or services will not be covered. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at **www.shpnc.gov** | Prescription drugs | 50% coinsurance after deductible | 60% coinsurance after deductible | Per 30-day supply. |
| | Affordable Care Act Preventive Medications | $0 | 60% coinsurance after deductible | Prescription must be written and filled at the pharmacy counter. |
| **If you have outpatient** | Facility fee (e.g., ambulatory | 50% coinsurance | 60% coinsurance after | ——————none—————— |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **surgery** | surgery center) | after deductible | deductible | |
| | Physician/surgeon fees | 50% coinsurance after deductible | 60% coinsurance after deductible | ——————none—————— |
| **If you need immediate medical attention** | Emergency room services | 50% coinsurance after deductible | 50% coinsurance after deductible | ——————none—————— |
| | Emergency medical transportation | 50% coinsurance after deductible | 50% coinsurance after deductible | ——————none—————— |
| | Urgent care | 50% coinsurance after deductible | 50% coinsurance after deductible | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 50% coinsurance after deductible | 60% coinsurance after deductible | No coverage for admissions prior to the effective date of coverage. Precertification may be required. |
| | Physician/surgeon fees | 50% coinsurance after deductible | 60% coinsurance after deductible | ——————none—————— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 50% coinsurance after deductible | 60% coinsurance after deductible | ——————none—————— |
| | Inpatient services | 50% coinsurance after deductible | 60% coinsurance after deductible | Precertification required. |
| | Substance use disorder outpatient services | 50% coinsurance after deductible | 60% coinsurance after deductible | ——————none—————— |
| | Substance use disorder inpatient services | 50% coinsurance after deductible | 60% coinsurance after deductible | Precertification required. |
| **If you are pregnant** | Office visits | 50% coinsurance after deductible | 60% coinsurance after deductible | Not covered for dependent children |
| | Childbirth/delivery inpatient professional services | 50% coinsurance after deductible | 60% coinsurance after deductible | |
| **If you need help recovering or have other special health needs** | Home health care | 50% coinsurance after deductible | 60% coinsurance after deductible | ——————none—————— |
| | Rehabilitation services | 50% coinsurance after deductible | 60% coinsurance after deductible | ——————none—————— |
| | Habilitation services | Not covered | Not covered | Excluded |
| | Skilled nursing care | 50% coinsurance | 60% coinsurance after | Coverage is limited to 100 days per benefit |

For more information about limitations and exceptions, see the plan benefit booklet at www.shpnc.gov.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | after deductible | deductible | period. Prior certification required. |
| | Durable medical equipment | 50% coinsurance | 60% coinsurance | ——————none—————— |
| | Hospice services | 50% coinsurance | 60% coinsurance | ——————none—————— |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | Excluded |
| | Children's glasses | Not covered | Not covered | Excluded |
| | Children's dental check-up | Not covered | Not covered | Excluded |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances.
- Cosmetic surgery
- Dental care (Child)
- Dental care (Adult)
- Glasses
- Habilitation services
- Hearing aids (age 22 and older)
- Long-term care
- Routine eye exam (Child)
- Routine eye exam (Adult)
- Enteral Formula
- Gender Affirming Surgery
- Routine foot care
- Skilled nursing facility over 100 days per benefit period

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Bariatric surgery
- Chiropractic care (up to 30 visits per benefit period)
- Air Ambulance
- Hearing aids (under age 22)
- Infertility treatment
- Non-emergency care when traveling outside the U.S. call 1-855-888-9046 (TTY: 711) or 959-230-8220 (TTY: 711). Ask for the Aetna Special Case Precertification Unit.
- Private Duty Nursing

For more information about limitations and exceptions, see the plan benefit booklet at www.shpnc.gov.

**Your Rights to Continue Coverage:** If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-833-690-1037. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 ~~x61565~~ or **www.cciio.cms.gov**

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: State Health Plan Customer Service at 866-740-3881or www.shpnc.gov. You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**, if applicable. You may also contact North Carolina Department of Insurance at (855) 408-1212 or www.ncdoi.com/smart.

**Does this plan provide Minimum Essential Coverage?** **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards?** **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
[Spanish (Español): Para obtener asistencia en Español, llame al [919-814-4400].
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [919-814-4400].
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [919-814-4400].
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [919-814-4400].

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

For more information about limitations and exceptions, see the plan benefit booklet at www.shpnc.gov.

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$5,000**
- **Specialist copayment** **50%**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductible | $5,000 |
| Copayments | $0 |
| Coinsurance | $3,870 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$8,870** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible**
- **Specialist copayment** **50%**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(additional test strips)*

| **Total Example Cost** | **$500** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $0 |
| Copayments | $0 |
| Coinsurance | $222.50 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$222.50** |

### Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

- **The plan's overall deductible** **$5,000**
- **Specialist copayment** **50%**
- **Hospital (facility) coinsurance** **50%**
- **Other coinsurance** **50%**

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(X-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$3,895** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,945 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $950 |
| **The total Mia would pay is** | **$2,945** |

*Note: The deductible has been satisfied in this scenario.

The **Plan** would be responsible for the other costs of these EXAMPLE covered services.