This Summary Schedule of Benefits is an excerpt from the proposed January 2019 Plan Summary for the North Carolina Dental Society Healthcare Plan. The proposed January 2019Plan Summary has been submitted to the North Carolina Department of Insurance (DOI) for review, but as of September 25, 2018 has not been approved. This Summary Schedule of Benefits is subject to change in connection with the DOI review process.

SUMMARY SCHEDULE OF BENEFITS

Plan A (Co-Pay Plan), Plan B (Deductible Plan), Plan C (High-Deductible Plan)

2019 Renewal Month Benefit Summary

The benefits provided by the Plan will be determined in accordance with the following schedules and subject to all Plan conditions, exclusions and limitations set out in this booklet.

COMPREHENSIVE MEDICAL BENEFITS FOR PPO PLAN A (CO-PAY)

The following is a Summary of Benefits for PPO Plan A.

For a more complete description of Covered Charges, applicable limitations, and exclusions, refer to the sections of the Plan Booklet entitled Health Care Benefits, Covered Charges for Health Care Benefits, Exclusions and Limitations.

Except as mandated by applicable laws, the percentages listed in the chart are the percentages of the provider's Reasonable and Customary charges that are payable by the Plan.

General Limits of Coverage	In-Network	Out-of-Network
Annual Deductible:	**Single:** $1,000 **Family:** $3,000	**Single:** $3,000 **Family:** $9,000
Out-of-Pocket Limit (includes deductible, coinsurance and copays for medical and prescription drugs):	**Single:** $5,000 **Family:** $10,000	**Single:** $8,000 **Family:** $16,000
Insured Percentage: (unless otherwise expressly stated)	80%	60%

General Services	In-Network	Out-of-Network
Primary Care Physician Office Visit:	$25 Co-Pay (waived for Preventive Care unless billed or tracked separately)	70%, subject to the Deductible
Specialist Office Visit:	$45 Co-Pay (waived for Preventive Care unless billed or tracked separately)	70%, subject to the Deductible
Urgent Care Facilities:	$45 Co-Pay	70%, subject to the Deductible

General Services	In-Network	Out-of-Network
Emergency Services: *(The Deductible is waived for the initial emergency room treatment of an accidental Injury, provided the services are rendered within 72 hours of the accident causing the Injury)*	$200 Co-Pay (waived if admitted); remaining charges paid at 80%, subject to the In-Network Deductible	
Maternity Care: (Prenatal and postnatal care)	80%, subject to the Deductible	60%, subject to the Deductible

Preventive Care, Diagnostic Procedures	In-Network	Out-of-Network
Routine Physicals: (including doctor's office X-rays, Lab Tests, Prostate screening, and GYN exams)	100%, Deductible waived	No Coverage, except that Mandated Benefits (see below) are covered the same as In-Network (Based on Network or Reasonable and Customary provider charges)
Newborn Baby and Well Child Care: (For children from birth through age 20) Including: medical exams, screenings, assessments, counseling		
Immunizations:		
Mammograms:		
Colonoscopy and Colorectal Cancer Screening: (For adults over age 50)		
Other Services Qualifying as Preventive Care:		
Diagnostic X-Ray and Laboratory other than Preventive Care: for services billed separately from the Physician office visit)	$25 Co-Pay	70%, subject to the Deductible
Pre-Admission Testing: (performed on an outpatient basis)	80%, subject to the Deductible	60%, subject to the Deductible

Hospital Services	In-Network	Out-of-Network
Penalty for failing to obtain pre-certification: (does not apply to Emergency Services)	$250	
Per Confinement Deductible: (applies in addition to Plan Deductible)	$0	$250
Inpatient:	80%, subject to the Deductible	60%, subject to the Deductible

Hospital Services	In-Network	Out-of-Network
Outpatient:	80%, subject to the Deductible	60%, subject to the Deductible
Maternity/Delivery:	80%, subject to the Deductible	60%, subject to the Deductible
Second Surgical Opinion: (mandatory for transplants only)	100%, Deductible waived	

Prescription Drugs	OptumRx Network Only
Extended Supply—OptumRx Prescription Drug Card: (mail order for 32 to 90 day supply) * Note – drugs and services for certain conditions provided only through OptumRx Specialty Pharmacy	$10 Co-Pay for generic $80 Co-Pay for formulary brand names $120 Co-Pay for non-formulary brand names
Short Term Supply—OptumRx Prescription Drug Card: (retail; maximum 31-day supply) *Note – drugs and services for certain conditions provided only through OptumRx Specialty Pharmacy	$5 Co-Pay for generic $40 Co-Pay for formulary brand names $60 Co-Pay for non-formulary brand names $100 Co-Pay for specialty

Vision Benefit	Cost Sharing	Limitations
Comprehensive Eye Exam:	No Co-Pay 100% covered	Coverage is limited to one exam every 12 months
Hardware: (Including lenses, frames and contact lenses)	$25 Co-Pay per purchase, then 100% covered (subject to certain limits – see adjacent box)	Individuals 19 years of age or older: coverage is limited to annual maximum of $125. Individuals under 19 years of age: coverage is limited to one set of eyeglass lenses or contact lenses every 12 months and one set of frames every 24 months.
Contact Lens Fitting	$35 co-pay, then 100% covered (subject to certain limits – see adjacent box)	Coverage is limited to one fitting every 12 months up to a maximum of $50

Other Services/Providers	In-Network	Out-of-Network
Ambulance Services:	80%, subject to the In-Network Deductible	
Skilled Nursing Facility:	80%, subject to the Deductible	60%, subject to the Deductible

Other Services/Providers	In-Network	Out-of-Network
Durable Medical Equipment:	80%, subject to the Deductible	60%, subject to the Deductible

Other Services/Providers	In-Network	Out-of-Network
Hearing Aids and Related Services and Supplies: (Limited to $2,500 per hearing aid every 36 months)	80%, subject to the Deductible	60%, subject to the Deductible
Home Health Care:	80%, subject to the Deductible	60%, subject to the Deductible
Infusion Therapy:	80%, subject to the Deductible	60%, subject to the Deductible
Hospice:	80%, subject to the Deductible	60%, subject to the Deductible
Physical Therapy, Spinal Manipulation//Chiropractic, and Occupational Therapy (30 visit plan year combined maximum):	80%, subject to the Deductible	60%, subject to the Deductible
Speech Therapy (30 visit plan year maximum):	80%, subject to the Deductible	60%, subject to the Deductible
TMJ:	80%, subject to the Deductible	60%, subject to the Deductible
Mental Health: (other than Preventive Care)	Office Visit: $25 Co-Pay Inpatient/Outpatient: 80%, subject to the Deductible	Office Visit: 70%, subject to the Deductible Inpatient/Outpatient: 70%, subject to the Deductible
Chemical Dependency: (other than Preventive Care)	Office Visit: $25 Co-Pay Inpatient/Outpatient: 80%, subject to the Deductible	Office Visit: 70%, subject to the Deductible Inpatient/Outpatient: 70%, subject to the Deductible

If a health care provider is not a Network Provider, the provider's services will be treated as out-of-network.

PLAN A CO-PAY PROVISIONS

Services rendered in the Primary Physician's Office: Most covered services provided by a Network Primary Physician in his or her office are subject to a $25 co-pay. There is no Deductible and the usual Coinsurance is not required.

If the services rendered in the primary Physician's office constitute Preventive Care, the Co-Pay is waived and no cost-sharing requirements will be imposed. However, the office visit Co-Pay is not waived if the Preventive Care is billed separately or is tracked as independent encounter data separately; or if the primary purpose of the office visit is not the delivery of Preventive Care.

Services rendered in the Specialist's Office: Most covered services provided by a Network Specialist in his or her office are subject to a $45 co-pay. There is no Deductible and the usual Coinsurance is not required.

If the services rendered in the specialist's office constitute Preventive Care, the Co-Pay is waived and no cost-sharing requirements will be imposed. However, the office visit Co-Pay is not waived if the Preventive Care is billed separately or is tracked as independent encounter data separately; or if the primary purpose of the office visit is not delivery of Preventive Care.

Services rendered by Physicians outside the Office: The Co-Pay benefit ***does not*** apply to charges for services rendered by the Physician in a place other than his or her office. For example, the Co-Pay benefit does not apply to the Physician's services in a Hospital or an Outpatient surgical center. Charges for these services are considered and benefits are paid as provided by the Plan.

Charges for Services rendered at an In-Network Urgent Care Center: A $45 Co-Pay will apply to charges for services received at a Network Urgent Care Center.

In-Network Lab and X-ray Services: In-Network lab and x-ray services that are billed separately from the Physician office visit will be subject to a separate $25 Co-Pay. If these services constitute Preventive Care, the Co-Pay is waived and no cost-sharing requirements will be imposed.

Services not included under the Office Visit Co-Pay: The office visit Co-Pay does not apply to some services. For example:

- The Co-Pay does not apply to Prescription Drugs;
- The Co-Pay does not apply to Cancer Treatments; and
- The Co-Pay does not apply to Physical, Speech, and Occupational Therapy.

These services are subject to the Plan Deductible and Coinsurance requirement. Also, they are subject to Plan exclusions and limitations.

PLAN A PREVENTIVE CARE

Certain In-Network preventive services are not subject to Co-Pays, the Plan Deductible, Coinsurance, or any other cost-sharing requirements. These Preventive Care services include, but are not limited to the following:

- Blood pressure screening;
- Diabetes screening;

- Cholesterol tests;
- Many cancer screenings;
- Counseling from health care providers on quitting smoking, losing weight, nutrition, treating depression and reducing alcohol use;
- Routine immunizations and vaccines;
- Regular well-baby and well-child visits.

PLAN A MANDATED BENEFITS

Except for certain "Mandated Benefits," Out-of-Network Preventive Care is not covered. Mandated Benefits include the following:

- Coverage for low-dose screening mammography for women over age 40;
- Coverage for cervical cancer screening, including coverage for the HPV vaccine;
- Coverage for surveillance tests for women age 25 and older at risk for ovarian cancer;
- For a qualified individual, coverage for colorectal cancer examinations and screening tests, and prostate-specific antigen tests or equivalent tests for the presence of prostate cancer. A qualified individual is an individual who is non-symptomatic and:
  At least 50 years of age; or
  At high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.
- For a qualified individual, coverage for bone mass measurement for diagnosis and evaluation of osteoporosis or low bone mass (once every 23 months unless more frequent measurement is medically necessary).
- Coverage for diabetes outpatient self-management training and educational services provided by a Physician or a health care professional designated by the Physician; and equipment, supplies, medications, and laboratory procedures used to treat diabetes.

Mandated Benefits are subject to the limitations and provisions of the section of the Plan Booklet entitled "Covered Charges for Health Care Benefits".

COMPREHENSIVE MEDICAL BENEFITS FOR PPO PLAN B (DEDUCTIBLE)

The following is a Summary of Benefits for PPO Plan B. For a more complete description of Covered Charges, applicable limitations, and exclusions, refer to the Plan Booklet sections entitled Health Care Benefits, Covered Charges for Health Care Benefits, Exclusions and Limitations. Except as mandated by applicable laws, the percentages listed in the chart are the percentages of the provider's Reasonable and Customary charges that are payable by the Plan.

General Limits of Coverage (not applicable to Prescription Drugs)	**In-Network**	**Out-of-Network**

Annual Deductible:	**Single:** $1,500 **Family:** $4,500	**Single:** $3,000 **Family:** $9,000
Out-of-Pocket Limit (includes deductible, coinsurance and copays for medical and prescription drugs):	**Single:** $6,000 **Family:** $12,000	**Single:** $9,000 **Family:** $18,000
General Limits of Coverage (not applicable to Prescription Drugs)	**In-Network**	**Out-of-Network**
Insured Percentage: (unless otherwise expressly stated)	70%	50%

General Services	**In-Network**	**Out-of-Network**
Primary Care Physician Office Visit:	$30 Co-Pay (Preventive Care covered 100% and Deductible waived unless billed or tracked separately)	50%, subject to the Deductible
Specialist Office Visit:	70%, subject to the Deductible	50%, subject to the Deductible
Urgent Care Facilities:	70%, subject to the Deductible	50%, subject to the Deductible
Emergency Services: *(The Deductible is waived for the initial emergency room treatment of an accidental Injury, provided the services are rendered within 72 hours of the accident causing the Injury)*	70%, subject to the In-Network Deductible	
Maternity Care: (Prenatal and postnatal care)	70%, subject to the Deductible	50%, subject to the Deductible

Preventive Care, Diagnostic Procedures	**In-Network**	**Out-of-Network**
Routine Physicals: (including doctor's office X-rays, Lab Tests, Prostate screening, and GYN exams)	100%, Deductible waived	No Coverage, except that Mandated Benefits (see below) are covered the same as In-Network (Based on Network or Reasonable and Customary provider charges)
Newborn Baby and Well Child Care: (For children birth through age 20) Including: medical exams, screenings, assessments, counseling		
Immunizations:		
Mammograms:		
Colonoscopy and Colorectal Cancer Screening: (For adults over age 50)		

Preventive Care, Diagnostic Procedures	In-Network	Out-of-Network
Other Services Qualifying as Preventive Care		
Diagnostic X-Ray and Laboratory other than Preventive Care: (for services billed separately from the Physician office visit)	$30 Co-Pay	50%, subject to the Deductible
Pre-Admission Testing: (performed on an outpatient basis)	70%, subject to the Deductible	50%, subject to the Deductible

Hospital Services	In-Network	Out-of-Network
Penalty for failing to obtain pre-certification: (does not apply to Emergency Services)	$250	
Per Confinement Deductible:	$0	$250
Inpatient:	70%, subject to the Deductible	50%, subject to the Deductible
Outpatient:	70%, subject to the Deductible	50%, subject to the Deductible
Maternity/Delivery:	70%, subject to the Deductible	50%, subject to the Deductible
Second Surgical Opinion: (mandatory for transplants only)	100%, Deductible waived	

Prescription Drugs	OptumRx Network Only
Extended Supply - OptumRx Prescription Drug Card: (mail order for 32 to 90 day supply) *Note – drugs and services for certain conditions provided only through OptumRx Specialty Pharmacy	$10 Co-Pay for generic $80 Co-Pay for formulary brand names $120 Co-Pay for non-formulary brand names
Short Term Supply - OptumRx Prescription Drug Card: (retail; maximum 31-day supply) *Note – drugs and services for certain conditions provided only through OptumRx Specialty Pharmacy	$5 Co-Pay for generic $40 Co-Pay for formulary brand names $60 Co-Pay for non-formulary brand names $100 Co-Pay for specialty

Vision Benefit	Cost Sharing	Limitations
Comprehensive Eye Exam:	No Co-Pay 100% covered	Coverage is limited to one exam every 12 months

Vision Benefit	Cost Sharing	Limitations
Hardware: (Including lenses, frames and contact lenses)	$25 Co-Pay per purchase, then 100% covered (subject to certain limits – see adjacent box)	Individuals 19 years of age or older: coverage is limited to annual maximum of $125. Individuals under 19 years of age: coverage is limited to one set of eyeglass lenses or contact lenses every 12 months and one set of frames every 24 months.
Contact Lens Fitting	$35 co-pay, then 100% covered (subject to certain limits – see adjacent box)	Coverage is limited to one fitting every 12 months up to a maximum of $50

Other Services/Providers	In-Network	Out-of-Network
Ambulance Services:	70%, subject to the In-Network Deductible	
Skilled Nursing Facility:	70%, subject to the Deductible	50%, subject to the Deductible
Durable Medical Equipment:	70%, subject to the Deductible	50%, subject to the Deductible
Hearing Aids and Related Services and Supplies: (Limited to $2,500 per hearing aid every 36 months)	70%, subject to the Deductible	50%, subject to the Deductible
Home Health Care:	70%, subject to the Deductible	50%, subject to the Deductible
Infusion Therapy:	70%, subject to the Deductible	50%, subject to the Deductible
Hospice:	70%, subject to the Deductible	50%, subject to the Deductible
Physical Therapy, Spinal Manipulation/Chiropractic, and Occupational Therapy (30 visit plan year combined maximum):	70%, subject to the Deductible	50%, subject to the Deductible
Speech Therapy (30 visit plan year maximum):	70%, subject to the Deductible	50%, subject to the Deductible
TMJ:	70%, subject to the Deductible	50%, subject to the Deductible
Mental Health: (other than Preventive Care)	Office Visit: $30 Co-Pay Inpatient/Outpatient: 70%, subject to the Deductible	Office Visit: 50%, subject to the Deductible Inpatient/Outpatient: 50%, subject to the Deductible

Other Services/Providers	In-Network	Out-of-Network
Chemical Dependency: (other than Preventive Care)	Office Visit: $30 Co-Pay Inpatient/Outpatient: 70%, subject to the Deductible	Office Visit: 50%, subject to the Deductible Inpatient/Outpatient: 50%, subject to the Deductible

If a health care provider is not a Network Provider, the provider's services will be treated as out-of-network.

PLAN B CO-PAY PROVISIONS

Services rendered in the Primary Physician's Office: Most covered services provided by a Network Primary Care Physician in his or her office are subject to a $30 co-pay. There is no Deductible and the usual Coinsurance is not required.

If the services rendered in the primary Physician's office constitute Preventive Care, the Co-Pay is waived and no cost-sharing requirements will be imposed. However, the office visit Co-Pay is not waived if the Preventive Care is billed separately or is tracked as independent encounter data separately; or if the primary purpose of the office visit is not the delivery of Preventive Care.

In-Network Lab and X-ray Services: In-Network lab and x-ray services that are billed separately from the Physician office visit will be subject to a separate $30 Co-Pay. If these services constitute Preventive Care, the Co-Pay is waived and no cost-sharing requirements will be imposed.

Services not included under the Office Visit Co-Pay: The office visit Co-Pay does not apply to some services. For example:

- The Co-Pay does not apply to Prescription Drugs;
- The Co-Pay does not apply to Cancer Treatments; and
- The Co-Pay does not apply to Physical, Speech, and Occupational Therapy.

These services are subject to the Plan Deductible and Coinsurance requirement. Also, they are subject to Plan exclusions and limitations.

PLAN B PREVENTIVE CARE

Certain In-Network preventive services are not subject to Co-Pays, the Plan Deductible, Coinsurance, or any other cost-sharing requirements. These Preventive Care services include, but are not limited to the following:

- Blood pressure screening;
- Diabetes screening;
- Cholesterol tests;

- Many cancer screenings;
- Counseling from health care providers on quitting smoking, losing weight, nutrition, treating depression and reducing alcohol use;
- Routine immunizations and vaccines;
- Regular well-baby and well-child visits.

The Plan Deductible and Coinsurance percentage will apply if the primary purpose of the office visit is not the delivery of Preventive Care. If the Preventive Care is billed separately or tracked as independent encounter data separately, the Plan deducible and Coinsurance percentage will apply to services that are not Preventive Care.

PLAN B MANDATED BENEFITS

Except for certain "Mandated Benefits," Out-of-Network Preventive Care is not covered. Mandated Benefits are covered in the same manner as In-Network Preventive Care. Mandated Benefits include the following:

- Coverage for low-dose screening mammography for women over age 40;
- Coverage for cervical cancer screening, including coverage for the HPV vaccine;
- Coverage for surveillance tests for women age 25 and older at risk for ovarian cancer;
- For a qualified individual, coverage for colorectal cancer examinations and screening tests, and prostate-specific antigen tests or equivalent tests for the presence of prostate cancer. A qualified individual is an individual who is non-symptomatic and:
  At least 50 years of age; or
  At high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.
- For a qualified individual, coverage for bone mass measurement for diagnosis and evaluation of osteoporosis or low bone mass (once every 23 months unless more frequent measurement is medically necessary).
- Coverage for diabetes outpatient self-management training and educational services provided by a Physician or a health care professional designated by the Physician, and equipment, supplies, medications, and laboratory procedures used to treat diabetes.

Mandated Benefits are subject to the limitations and provisions of the Plan Booklet section entitled "Covered Charges for Health Care Benefits".

COMPREHENSIVE MEDICAL BENEFITS FOR PPO PLAN C (HIGH-DEDUCTIBLE PLAN)

The following is a Summary of Benefits for PPO Plan C. For a more complete description of Covered Charges, applicable limitations, and exclusions, refer to the sections of the Plan Booklet entitled Health Care Benefits, Covered Charges for Health Care Benefits, Exclusions and

Limitations. Except as mandated by applicable laws, the percentages listed in the chart are the percentages of the provider's Reasonable and Customary charges that are payable by the Plan.

General Limits of Coverage	In-Network	Out-of-Network
Annual Deductible:	**Single Coverage:** $3,000 **Family Coverage:** $6,000	**Single Coverage:** $6,000 **Family Coverage:** $12,000
Out-of-Pocket Limit (includes deductible, coinsurance and copays for medical and prescription drugs):	**Single:** $6,000 **Family:** $12,000	**Single:** $10,000 **Family:** $20,000
Insured Percentage (unless otherwise expressly stated):	70% after Deductible	50% after Deductible

General Services	In-Network	Out-of-Network
Primary Care Physician Office Visit:	70%, subject to the Deductible (Preventive Care covered 100% and Deductible waived unless billed or tracked separately)	50%, subject to the Deductible
Specialist Office Visit:	70%, subject to the Deductible	50%, subject to the Deductible
Urgent Care Facilities:	70%, subject to the Deductible	50%, subject to the Deductible
Emergency Services:	70%, subject to the In-Network Deductible	
Maternity Care: (Prenatal and postnatal care)	70%, subject to the Deductible	50%, subject to the Deductible

Preventive Care, Diagnostic Procedures	In-Network	Out-of-Network
Routine Physicals: (including doctor's office X-rays, Lab Tests, Prostate screening, and GYN exams)	100%, Deductible waived	No Coverage, except that Mandated Benefits (see below) are covered the same as In-Network (Based on Network or Reasonable and Customary provider charges)
Newborn Baby and Well Child Care: (For children birth through age 20) Including: medical exams, screenings, assessments, counseling		
Immunizations:		
Mammograms:		

Preventive Care, Diagnostic Procedures	In-Network	Out-of-Network
Colonoscopy and Colorectal Cancer Screening: (For adults over age 50)		
Other Services Qualifying as Preventive Care:		
Diagnostic X-Ray and Laboratory other than Preventive Care: (for services billed separately from the Physician office visit):	70%, subject to the Deductible	50%, subject to the Deductible
Pre-Admission Testing: (performed on an outpatient basis)	70%, subject to the Deductible	50%, subject to the Deductible

Hospital Services	In-Network	Out-of-Network
Penalty for failing to obtain pre-certification: (does not apply to Emergency Services)	$250	
Inpatient:	70%, subject to the Deductible	50%, subject to the Deductible
Outpatient:	70%, subject to the Deductible	50%, subject to the Deductible
Maternity/Delivery:	70%, subject to the Deductible	50%, subject to the Deductible
Second Surgical Opinion: (mandatory for transplants only)	100%, Deductible waived	

Prescription Drugs	OptumRx Network Only
OptumRx Prescription Drug Card (retail or mail order): *Note – drugs and services for certain conditions provided only through OptumRx Specialty Pharmacy.	100%, subject to the In-Network Deductible

Vision Benefit	Cost Sharing	Limitations
Comprehensive Eye Exam:	No Co-Pay 100% covered	Coverage is limited to one exam every 12 months

Vision Benefit	Cost Sharing	Limitations
Hardware: (Including lenses, frames and contact lenses)	$25 Co-Pay per purchase, then 100% covered (subject to certain limits – see adjacent box)	Individuals 19 years of age or older: coverage is limited to annual maximum of $125. Individuals under 19 years of age: coverage is limited to one set of eyeglass lenses or contact lenses every 12 months and one set of frames every 24 months.
Contact Lens Fitting	$35 co-pay, then 100% covered (subject to certain limits – see adjacent box)	Coverage is limited to one fitting every 12 months up to a maximum of $50

Other Services/Providers	In-Network	Out-of-Network
Ambulance Services:	70%, subject to the In-Network Deductible	
Skilled Nursing Facility:	70%, subject to the Deductible	50%, subject to the Deductible
Durable Medical Equipment:	70%, subject to the Deductible	50%, subject to the Deductible
Hearing Aids and Related Services and Supplies: (Limited to $2,500 per hearing aid every 36 months)	70%, subject to the Deductible	50% subject to the Deductible
Home Health Care:	70%, subject to the Deductible	50%, subject to the Deductible
Infusion Therapy:	70%, subject to the Deductible	50%, subject to the Deductible
Hospice:	70%, subject to the Deductible	50%, subject to the Deductible
Physical Therapy, Spinal Manipulation/Chiropractic, and Occupational Therapy (30 visit plan year combined maximum):	70%, subject to the Deductible	50%, subject to the Deductible
Speech Therapy (30 visit plan year maximum):	70%, subject to the Deductible	50%, subject to the Deductible
Mental Health: (other than Preventive Care)	Office Visit: 70%, subject to the Deductible Inpatient/Outpatient: 70%, subject to the Deductible	Office Visit: 50%, subject to the Deductible Inpatient/Outpatient: 50%, subject to the Deductible
TMJ:	70%, subject to the Deductible	50%, subject to the Deductible

Other Services/Providers	In-Network	Out-of-Network
Chemical Dependency: (other than Preventive Care)	Office Visit: 70%, subject to the Deductible Inpatient/Outpatient: 70%, subject to the Deductible	Office Visit: 50%, subject to the Deductible Inpatient/Outpatient: 50%, subject to the Deductible

If a health care provider is not a Network Provider, the provider's services will be treated as out-of-network.

PLAN C PREVENTIVE CARE

Certain In-Network preventive services are not subject to office visit Co-Pays, the Plan Deductible, Coinsurance, or any other cost-sharing requirements. These Preventive Care services include, but are not limited to the following:

- Blood pressure screening;
- Diabetes screening;
- Cholesterol tests;
- Many cancer screenings;
- Counseling from health care providers on quitting smoking, losing weight, nutrition, treating depressing and reducing alcohol use;
- Routine immunizations and vaccines;
- Regular well-baby and well-child visits.

The Plan Deductible and Coinsurance percentage will apply if the primary purpose of the office visit is not the delivery of Preventive Care. If the Preventive Care is billed separately or tracked as independent encounter data separately, the Plan deducible and Coinsurance percentage will apply to services that are not Preventive Care.

PLAN C MANDATED BENEFITS

Except for certain "Mandated Benefits," Out-of-Network Preventive Care is not covered. Mandated Benefits are covered in the same manner as In-Network Preventive Care. Mandated Benefits include the following:

- Coverage for low-dose screening mammography for women over age 40;
- Coverage for cervical cancer screening, including coverage for the HPV vaccine;
- Coverage for surveillance tests for women age 25 and older at risk for ovarian cancer;
- For a qualified individual, coverage for colorectal cancer examinations and screening tests, and prostate-specific antigen tests or equivalent tests for the presence of prostate cancer. A qualified individual is an individual who is non-symptomatic and:
  At least 50 years of age; or

At high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

- For a qualified individual, coverage for bone mass measurement for diagnosis and evaluation of osteoporosis or low bone mass (once every 23 months unless more frequent measurement is medically necessary).
- Coverage for diabetes outpatient self-management training and educational services provided by a Physician or a health care professional designated by the Physician, and equipment, supplies, medications, and laboratory procedures used to treat diabetes.

Mandated Benefits are subject to the limitations and provisions of the section of the Plan Booklet entitled "Covered Charges for Health Care Benefits".

SPECIAL PROVISIONS APPLICABLE TO ALL PLAN OPTIONS

Under each of the Plan options, Emergency Services received from an out-of-network provider shall be paid at the In-Network level.

A special rule applies if you are treated at a Network facility, and your primary Physician or surgeon while you are in the facility is also In-Network. In that case, the Covered Charges from other Physicians may be paid at the In-Network level of benefit.

This Summary Schedule of Benefits is only a summary of what the Plan covers. You can find more information in the Plan Booklet.