



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, www.bcbsnc.com/booklets. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-579-8022 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network- \$300 Individual/\$0 Family Total. Out-of-Network- Doesn't apply to In-Network <u>preventive care</u> . <u>Coinsurance</u> and <u>copayments</u> do not apply to the <u>deductible</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. <u>Preventive services</u> .	For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan? What is not included in the out-of-pocket limit?	In-Network- \$4,000 Individual/\$0 Family Total. Out-of-Network- <u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>plan</u> doesn't cover and penalties for failure to obtain <u>pre-authorization</u> for services.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.bcbsnc.com/FindADoctor or call 1-800-579-8022 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a referral to see a specialist?

No.

You can see the specialist you choose without a referral.



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	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	-You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services are <u>preventive</u> . Then check what your <u>plan</u> will pay for.- Limits may apply
	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-Prior review and certification of services may be required or services will not be covered
If you need drugs to treat your illness or condition	Tier 1 Drugs	\$4/prescription	\$4/prescription	- * See Prescription Drug section. - For Infertility dosage limits apply - Minimum of \$100 in <u>coinsurance</u> but no more than \$200 for tier 5 drugs
	Tier 2 Drugs	\$25/prescription	\$25/prescription	
	Tier 3 Drugs	\$35/prescription	\$35/prescription	

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More information about prescription drug coverage is available at www.bcbsnc.com/rxinfo	Tier 4 Drugs	\$75/prescription	\$75/prescription	
	Tier 5 Drugs	25% <u>coinsurance</u> with min/max/ prescription	25% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-Prior review and certification of services may be required or services will not be covered
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-Prior review and certification of services may be required or services will not be covered
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-Prior review and certification of services may be required or services will not be covered

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 are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-*See Family planning section. - <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-No coverage for maternity for dependent children.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-Precertification may be required
	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-Prior review and certification of services may be required or services will not be covered
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-*See Therapies section -30 visits/benefit period includes PT/OT/Chiropractic Care. -30 visits/benefit period Speech Therapy
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	- <u>Habilitation services</u> are combined with the <u>Rehabilitation service</u> limits listed above.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-Coverage is limited to 60 days per benefit period. -Prior review and certification of services may be required or services will not be covered

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 your child needs dental or eye care	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-Prior review and certification of services may be required or services will not be covered -Limits may apply
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-Precertification may be required
	Children's eye exam	No charge	Not Covered	-Limits may apply
	Children's glasses	20% coinsurance after deductible	20% coinsurance after deductible	-Limited to one pair of glasses or contacts per benefit period
	Children's dental check-up	No charge	50% <u>coinsurance after deductible</u>	-Limited to twice per benefit period

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
- Long-term care, respite care, rest cures
- Cosmetic surgery and services
- Routine Foot Care
- Dental care (Adult)
- Weight loss programs

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

- Bariatric surgery
- Infertility treatment
- Routine eye care (Adult)
- Chiropractic care
- Non-emergency care when traveling outside the U.S. (PPO). Coverage provided outside the United States. See www.bcbsnc.com
- Hearing aids up to age 22
- Private duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or BCBSNC at 1-877-258-3334 or www.BlueConnectNC.com. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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: BCBSNC at 1-877-258-3334 or www.BlueConnectNC.com. You may also contact N.C. Department of Insurance at 1201 Mail Service Center, Raleigh, NC 27699-1201, or Toll free (855) 408-1212. 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.

Additionally, a consumer assistance program can help you file your appeal. Contact Health Insurance Smart NC, N.C. Department of Insurance, at 1201 Mail Service Center, Raleigh, NC 27699-1201, 855-408-1212 (toll free).

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 the 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 número que aparece al respaldo de su tarjeta del seguro.

Tagalog (Tagalog): Para matulungan sa Tagalog, tawagan ang numerong nasa likuran ng insurance card.

Chinese (中文): 如需國語或廣東話協助，請致電您保險卡背面的電話號碼。

Navajo (Dine): Diné bizaad bee shíká'adoowoł nínzingo kwoji' hólné', naaltsoos áłts'ísí nantinígíí bine'déé' binámboo bikáá'.

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

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)

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

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

- **The plan's overall deductible** \$300
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

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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*)

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

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 \$12,800

Total Example Cost \$7,400

Total Example Cost \$1,900

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$20
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,700

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$100
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,100

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$0
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$600

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