



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.bluecrossnc.com. 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- \$600 Individual. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible. | 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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| 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? | In-Network- \$4,000 Individual/\$0 Family Total. Out-of-Network- \$8,000 Individual/\$0 Family Total. <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. |
| What is not included in the out-of-pocket limit? | | 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 <u>network providers</u> . | 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 <u>provider's</u> 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 | |

| 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) | |
| 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> /prescription | 25% <u>coinsurance</u> | |
| 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 | Emergency medical <u>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 | 50% coinsurance no deductible | 50% coinsurance no deductible | -Limited to one pair of glasses or contacts per benefit period |
| | Children's dental check-up | 0% <u>coinsurance</u> no deductible | 30% <u>coinsurance</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.bluecrossnc.com
- Hearing aids
- 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. 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: Blue Cross NC at 1-877-275-9787 or www.BlueConnectNC.com. 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.

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 shiká'adoowol 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)

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

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 | |
|-----------------------------------|----------------|
| Deductibles | \$300 |
| Copayments | \$20 |
| Coinsurance | \$2,300 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,700 |

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

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

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*)

Total Example Cost \$7,400

In this example, Joe would pay:

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

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%

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 \$1,900

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| Deductibles | \$300 |
| Copayments | \$0 |
| Coinsurance | \$300 |
| What isn't covered | |
| 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.



Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina ("BCBSNC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
 - BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
- BCBSNC:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
 - Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages
- If you need these services, contact Customer Service **1-888-206-4697**, TTY and TDD, call **1-800-442-7028**.
 - If you believe that BCBSNC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
 - BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone **919-765-1663**, Fax **919-287-5613**, TTY **1-888-291-1783** civilrightscordinator@bcbsnc.com
 - You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator - Privacy, Ethics & Corporate Policy Office is available to help you.
 - You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **1-800-368-1019, 800-537-7697** (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.
 - This Notice and/or attachments may have important information about your application or coverage through BCBSNC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call Customer Service **1-888-206-4697**.



ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-206-4697 (TTY: 1-800-442-7028).

注意：如果您講廣東話或普通話，您可以免費獲得語言援助服務。請致電 1-888-206-4697 (TTY: 1-800-442-7028)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-206-4697 (TTY: 1-800-442-7028).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-888-206-4697 (TTY: 1-800-442-7028)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-206-4697 (ATS : 1-800-442-7028).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متوفرة لك بالمجان. اتصل برقم 1-800-442-7028. المبرقة الكتابة: 1-888-206-4697

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-206-4697 (TTY: 1-800-442-7028).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-206-4697 (телефайп: 1-800-442-7028).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-206-4697 (TTY: 1-800-442-7028).

සුඛඛ: ඔබ ඉංග්‍රීසි භාෂාවෙන් කතා කරන්නේ නම්, අප ඔබට නොමිලේ භාෂා සහාය සේවාවක් සැපයීමට සූදාසන්ධි කර ඇත. 1-888-206-4697 (TTY: 1-800-442-7028) දුරකථන අංකයෙන් අපව දන්න.

ထိုက်: ဗြိတိသျှဆူကုန်ကုမ္ပဏီလီမိတက်သည် အာရှတိုက်ရှိ မြန်မာနိုင်ငံတော်ရှိ မြန်မာများအတွက် အခမဲ့ ဗဟုသုတ ပေးအပ်မှုများကို ပေးအပ်ပါသည်။
ဆူကုန်ကုမ္ပဏီလီမိတက်: 1-888-206-4697 (TTY: 1-800-442-7028)။

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-206-4697 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-206-4697 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ແມ່ນມີຮ້ອນໃຫ້ທ່ານ. ໂທ 1-888-206-4697 (TTY: 1-800-442-7028).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697 (TTY: 1-800-442-7028) まで、お電話にてご連絡ください。