



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.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 <https://www.healthcare.gov/sbc-glossary/> or call 1-877-258-3334 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network \$2,000 Individual / \$4,000 Family Total. Out-of-Network \$4,000 Individual / \$8,000 Family Total.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, 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 care</u> and most services that may require a <u>copayment</u> .	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without cost sharing 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, there are no other specific deductibles.	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 / \$8,000 Family Total. Out-of-Network \$8,000 Individual / \$16,000 Family Total.	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 plan, 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?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this plan doesn't cover and penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why this Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbsnc.com/FindADoctor or call 1-877-258-3334 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in (Tier 1). You pay more if you use a <u>provider</u> in (Tier 2). 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 <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 office</u> or clinic	Primary care visit to treat an injury or illness	\$15 copayment / visit	50% after deductible / visit	None
	<u>Specialist</u> visit	\$30 copayment / visit for Tier 1; \$60 copayment / visit for Tier 2	50% after deductible / visit	None
	<u>Preventive</u> care/ <u>screening</u> /immunization	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 you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Limits may apply.
	<u>Diagnostic test</u> (x-ray, blood work)	20% after deductible / visit for Tier 1; 40% after deductible / visit for Tier 2	50% after deductible	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% after deductible / visit for Tier 1; 40% after deductible / visit for Tier 2	50% after deductible	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 need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <u>www.bcbsnc.com/rxinfo</u>	Tier 1 Drugs	\$4 copayment	\$4 copayment	No coverage for drugs in excess of quantity limits, or therapeutically equivalent to an over the counter drug. Other coverage limits may apply. *See <u>Prescription Drug Section</u> .
	Tier 2 Drugs	\$15 copayment	\$15 copayment	
	Tier 3 Drugs	\$35 copayment	\$35 copayment	
	Tier 4 Drugs	\$50 copayment	\$50 copayment	Same as above.
	Tier 5 Drugs	25%	25%	Same as above. You must pay a minimum of \$50 in <u>coinsurance</u> but no more than \$100.
	Tier 6 Drugs	50%	50%	Same as above. You must pay a minimum of \$50 in <u>coinsurance</u> but no more than \$200.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible / visit for Tier 1; 40% after deductible / visit for Tier 2	50% after deductible	None
	Physician/surgeon fees	20% after deductible / visit for Tier 1; 40% after deductible / visit for Tier 2	50% after deductible	None
If you need immediate medical attention	<u>Emergency room care</u>	\$500 copayment / visit	\$500 copayment / visit	None
	<u>Emergency medical transportation</u>	20% after deductible	20% after deductible	None
	<u>Urgent care</u>	\$30 copayment / visit	\$30 copayment / visit	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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible / visit for Tier 1; \$500 per admission copay then 40% after deductible / visit for Tier 2	\$500 per admission copay then 50% after deductible	Prior review and certification of services may be required or services will not be covered
	Physician/surgeon fees	20% after deductible / visit for Tier 1; 40% after deductible / visit for Tier 2	50% after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copayment / office visit; 20% after deductible / outpatient for Tier 1 / \$60 copayment / office visit; 40% after deductible / outpatient for Tier 2	50% after deductible	Prior review and certification of services may be required or services will not be covered
	Inpatient services	20% after deductible / visit for Tier 1; 40% after deductible / admission then \$500 per admission copay / visit for Tier 2	\$500 per admission copay then 50% after deductible	Precertification may be required.

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	\$15 copayment / visit	50% after deductible / visit	*See Family planning section.
	Childbirth/delivery professional services	20% after deductible / visit for Tier 1; 40% after deductible / visit for Tier 2	50% after deductible	None
	Childbirth/delivery facility services	20% after deductible / visit for Tier 1; \$500 per admission copay / admission then 40% after deductible / visit for Tier 2	\$500 per admission copay then 50% after deductible	Precertification may be required
If you need help recovering or have other special health needs	<u>Home health care</u>	20% after deductible	50% after deductible	Prior review and certification of services may be required or services will not be covered.
	<u>Rehabilitation services</u>	\$30 copayment	50% after deductible	30 visits / benefit period for physical / occupational therapy and chiropractic services. 30 visits / benefit period for speech therapy
	<u>Habilitation services</u>	\$30 copayment	50% after deductible	30 visits / benefit period for physical / occupational therapy and chiropractic services. 30 visits / benefit period for speech therapy
	<u>Skilled nursing care</u>	20% after deductible	50% after deductible	Coverage is limited to 60 days per benefit period. Prior review and certification of services may be required or services will not be covered for all <u>plans</u> .
	<u>Durable medical equipment</u>	20% after deductible	50% after deductible	Prior review and certification of services may be required or services will not be covered. Limits may apply.
	<u>Hospice services</u>	20% after deductible	50% after deductible	Precertification may be required for inpatient services.

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	Children's eye exam	\$15 copayment	50% after deductible	Limits may apply.
	Children's glasses	50% no deductible	50% no deductible	Limited to one pair of glasses or contacts per benefit period.
	Children's dental check-up	No Charge	30% after deductible	Limited to twice per benefit period.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)	
- Acupuncture - Cosmetic Surgery - Dental Care (Adult) - Routine Eye Care (Adult)	- Long Term Care, Respite Care, Rest Cures - Routine Foot Care - Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)	
- Bariatric Surgery - Chiropractic Care - Non-emergency care when traveling outside the U.S. Coverage outside of the United States see www.BlueCrossNC.com	- Hearing aids up to age 22 - Infertility Treatment - Private duty nursing

* For more information about limitations and exceptions, see plan or policy document at www.bcbsnc.com/booklets

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 North Carolina Insurance Consumer Assistance Program at www.ncdoi.com/Smart or 1-855-408-1212 or contact Blue Cross NC at 1-877-258-3334 or 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:

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: Health Insurance Smart NC at 1201 Mail Service Center, Raleigh, NC 27699-1201, or toll free 1-855-408-1212.

Additionally, a consumer assistance program can help you file your appeal. Contact Health Insurance Smart NC at 1201 Mail Service Center, Raleigh, NC 27699-1201, or toll free 1-855-408-1212.

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 1-877-258-3334.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-258-3334.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-258-3334.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-258-3334.

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 \$2,000
 - Specialist copayment \$30
 - Hospital (facility) coinsurance 20%
 - Other coinsurance 20%
- copayment

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$20
Coinsurance	\$1,900
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,000

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

- The plan's overall deductible \$2,000
 - Specialist copayment \$30
 - Hospital (facility) coinsurance 20%
 - Other coinsurance 20%
- copayment

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$300
Coinsurance	\$80
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$2,400

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

- The plan's overall deductible \$2,000
 - Specialist copayment \$30
 - Hospital (facility) coinsurance 20%
 - Other coinsurance 20%
- copayment

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-877-258-3334

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 تتوافر لك بالمجان. اتصل برقم 1-888-206-4697. المبرقة الكاتبة: 1-800-442-7028.

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 (телетайп: 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).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃસુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-206-4697 (TTY: 1-800-442-7028).

ចំណាំ: ប្រសិនបើលោកអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ សូមទំនាក់ទំនងតាមរយៈលេខ៖ 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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. 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。