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.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 1-877-275-9787 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: $1,500 Individual/$3,000 Family. Out-of-Network: $3,000 Individual/$6,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meet the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and most services that may require a copayment.	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.
What is the out-of-pocket limit for this plan?	In-Network: $4,250 Individual/$8,500 Family. Out-of-Network: $8,500 Individual/$17,000 Family.	The out-of-pocket limit 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 out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsnc.com/FindADoctor or call 1-877-275-9787 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider 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	$30 copayment	30% coinsurance	None
	Specialist visit	$50 copayment	30% coinsurance	None
	Federally-mandated Preventive care/screening/ immunization	No Charge	Not Covered	-You may have to pay for servicesthat aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.- Limits may apply
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	-Prior authorization may be required or services will not be covered
	Generic drugs	$9/30 day supply	$9/30 day supply	- $27/90 day supply
	Preferred brand drugs	$35/30 day supply	$35/30 day supply	- $105/90 day supply

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	Non-preferred brand drugs	$65/30 day supply	$65/30 day supply	- $195/90 day supply No coverage for drugs in excess of quantity limits or therapeutically equivalent to an over the counter drug
	Specialty drugs	25% coinsurance	25% coinsurance	- You up to $150 maximum - 30 day supply limit
	Diabetic supplies	25% coinsurance	25% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copayment	$250 copayment	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50 copayment	$50 copayment	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	-Prior authorization may be required or services will not be covered
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30/office visit; 20% coinsurance / outpatient	30% coinsurance; 40% coinsurance / outpatient	-Prior authorization may be required or services will not be covered
	Inpatient services	20% coinsurance	40% coinsurance	-Prior authorization 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	Initial office visit	$30 copayment	30% coinsurance	-This benefit applies in limited situations. *See Family Planning section.
	Childbirth/delivery professional services	$200 copayment	30% coinsurance	-No coverage for maternity for dependent children. -Copay applies to the professional global and delivery charges
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	-Prior authorization may be required or services will not be covered
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	-Prior authorization may be required or services will not be covered
	Rehabilitation services	$50 / office visit; 20% coinsurance / outpatient	30% coinsurance; 40% coinsurance / outpatient	-*See Therapies section -Combined 30 visits for physical/occupational therapy. -30 visits for speech therapy -30 visits for chiropractic services -$40,000 max/benefit period for Adaptive Behavior Treatment (up to age 19).
	Habilitation services	$50 / office visit; 20% coinsurance / outpatient	30% coinsurance; 40% coinsurance / outpatient	-Habilitation services are combined with the Rehabilitation service limits listed above.
	Skilled nursing care	20% coinsurance	40% coinsurance	-Coverage is limited to 60 days -Prior authorization 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)	
	Durable medical equipment	20% coinsurance	40% coinsurance	-Prior authorization may be required or services will not be covered -Limits may apply
	Hospice services	20% coinsurance	40% coinsurance	-Prior authorization may be required or services will not be covered
If your child needs dental or eye care	Children's routine eye exam	No Charge	30% coinsurance	-Limits mayapply
	Children's glasses	Not Covered	Not Covered	Excluded Service
	Children's dental check-up	Not Covered	Not Covered	Excluded Service

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
- Cosmetic surgery
- Dental care
- Long-term care
- Routine Foot Care
- 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
- Chiropractic care
- Hearing aids up to age 22
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private dutynursing
- Routine eye care

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

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

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: BCBSNC 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 1-877-275-9787.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-275-9787.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-275-9787.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-275-9787.

----------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	$1,500
Specialist copayment	$50
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 $12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,980
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,540**

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

The plan's overall deductible	$1,500
Specialist copayment	$50
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 $5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,320
Copayments	$300
Coinsurance	$540
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,180**

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

The plan's overall deductible	$1,500
Specialist copayment	$50
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 $2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$300
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,870**

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

BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified interpreters and/or written information in other formats (large print, accessible electronic formats, etc.)
- Free language services to people whose primary language is not English, such as: qualified interpreters and/or information written in other languages

If you need these services, call the Customer Service or TTY number on the back of your member ID card.

If you believe that Blue Cross NC 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:

Blue Cross NC, P.O. Box 2291, Durham, NC 27702
Attention: Civil Rights Coordinator-Privacy,
Ethics & Corporate Policy Office
Call: 919-765-1663, 1-888-291-1783 (TTY)
Fax: 919-287-5613
E-mail: civilrightscoordinator@bcbsnc.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the 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:

Online: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Mail: U.S. Department of Health & Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C., 20201
Call: 1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available online at:
http://www.hhs.gov/civil-rights/filing-a-complaint/index.html

This notice and/or attachments may have important information about your application or coverage through Blue Cross NC. 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. If you need these services, call the Customer Service or TTY number on the back of your member ID card.

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Discrimination is Against the Law

Blue Cross NC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Blue Cross NC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

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BlueCross BlueShield of North Carolina

Multi-language Interpreter Services

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call the Customer Service or TTY number on the back of your member ID card.

ATENCIÓN: Si habla otro idioma, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicio de Atención al Cliente al número de teléfono para personas con problemas auditivos (TTY) que figura al dorso de su tarjeta de identificación.

注意：他の言語を話す方は、言語支援サービスを無料でご利用いただけます。
顧客サービスにお電話いただくか、会員IDカードの裏面にあるTTYサービスをご利用ください。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Dịch vụ khách hàng hoặc TTY trên mặt sau thẻ ID thành viên của bạn.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
가입자 ID 카드 뒷면에 있는 고객 서비스 혹은 TTY 번호로 전화해 주십시오.

ATTENTIONₒ: si vous parlez une autre langue, des services d'aide linguistique vous sont proposés gratuitement. Contactez le service clients au numéro figurant au dos de votre carte de membre.

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم خدمة العملاء أو رقم الهاتف النصي الموضح على ظهر بطاقة هوية العضو.

LUS CEEB TOOM:Yog tias koj hais lus Hmoob, , peb muaj kev pab txhais lus pub dawb rau koj. Hu rau Customer Service tus xov tooj los yog tus xov tooj TTY rau cov neeg tsis hnov lus zoo uas nyob sab tom qab koj daim npav ID.

ВНИМАНИЕ: Если вы говорите на другом языке, то вам доступны бесплатные услуги перевода. Позвоните в Отдел обслуживания по номеру, указанному на обратной стороне вашей идентификационной карточки участника.

PAUNAWA: Kung nagsasalita ka ng ibang lengguwahe, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numero ng Customer Service o TTY sa likod ng iyong member ID card.

સૂચના: જો તમે ગુજરાતી બોલતા હોવ તો તમારા માટે ભાષા સેવાઓ નિ:શુ ક ઉપલ ધ છે. તમારા સ ચપદ ઓળખપ ૨ની (આઈ.ડી) પાછળની બાજુ પર આપેલ ગરાહક સેવાઓના નંબર અથવા TTT નંબર પર કૉલ કરો.

ចំណាំ៖ ប្រសិនប្រាកអ្នកនិយាយជាភាសាខ្មែរ បសវាកមជំនួយអ្នកភាសាមានផ្តល់ជូនសបមាប្រាកអ្នកដោយមិនគិតថ្លៃ។សូមបៅបៅកា ន់បស វាអត្ថិជនដោយបប្របលទូរស័ព្ទបៅខាងក្រៅតសមាជិកប្រុស់ដោកអ្នក។

ACHTUNG: Falls Sie eine andere Sprache sprechen, stehen Ihnen kostenlose Sprachdienste zur Verfügung. Rufen Sie die Nummer des Kundenservices oder von TTY an, die auf der Rückseite Ihrer Mitgliedskarte angegeben ist.

ध्यान दें: यदि आप दूसरी भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं, मुफ्त में, उपलब्ध हैं। अपने सदस्य आईडी कार्ड के पीछे मौजूद ग्राहक सेवा या TTY नंबर पर कॉल करें।

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາອື່ນ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການລູກຄ້າຫາລື ເບີ TTY ຢູ່ດ້ານຫຼັງບັດປະຈຳຕົວຂອງທ່ານ.

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。請撥打您會員 ID 卡背面的客服或 TTY號的電話號碼。

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