
 **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: \$2,000 Individual/\$4,000 Family. Out-of-Network: \$4,000 Individual/\$8,000 Family.	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 meet 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 <u>plan</u> 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 <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: \$5,250 Individual/\$10,500 Family. Out-of-Network: \$10,500 Individual/\$21,000 Family.	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?	<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.	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 1-877-275-9787 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 <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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 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	\$30 <u>copayment</u>	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$50 <u>copayment</u>	30% <u>coinsurance</u>	None
	Federally-mandated Preventive care/screening/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 needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.- Limits may apply
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-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)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copayment</u>	\$250 <u>copayment</u>	None
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$50 <u>copayment</u>	\$50 <u>copayment</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-Prior authorization may be required or services will not be covered
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30/office visit; 30% coinsurance / outpatient	30% <u>coinsurance</u> ; 50% <u>coinsurance</u> / outpatient	-Prior authorization may be required or services will not be covered
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-Prior authorization may be required or services will not be covered

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

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 <u>copayment</u>	30% <u>coinsurance</u>	-This benefit applies in limited situations. *See Family Planning section.
	Childbirth/delivery professional services	\$200 copayment	30% <u>coinsurance</u>	-No coverage for maternity for dependent children. -Copay applies to the professional global and delivery charges
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-Prior authorization may be required or services will not be covered
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-Prior authorization may be required or services will not be covered
	<u>Rehabilitation services</u>	\$50 / office visit; 30% <u>coinsurance</u> / outpatient	30% <u>coinsurance</u> ; 50% <u>coinsurance</u> / outpatient	-*See Therapies section -Combined 30 visits for physical/occupational therapy. -30 visits for speech therapy -30 visits for chiropractic services, visits with mental illness diagnoses don't apply
	<u>Habilitation services</u>	\$50 / office visit; 30% <u>coinsurance</u> / outpatient	30% <u>coinsurance</u> ; 50% <u>coinsurance</u> / outpatient	- <u>Habilitation services</u> are combined with the <u>Rehabilitation service</u> limits listed above.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-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)	
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-Prior authorization may be required or services will not be covered -Limits may apply
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-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% <u>coinsurance</u>	-Limits may apply
	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
- Long-term care
- Cosmetic surgery
- Routine foot care that is palliative or cosmetic
- Dental 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
- Infertility treatment
- Routine eye care
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- 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: 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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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, kwijigo 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** \$2,000
- **Specialist copayment** \$50
- **Hospital (facility) coinsurance** 30%
- **Other coinsurance** 30%

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:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$2,820
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,880

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** \$50
- **Hospital (facility) coinsurance** 30%
- **Other coinsurance** 30%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,320
Copayments	\$300
Coinsurance	\$820
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,460

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

- **The plan's overall deductible** \$2,000
- **Specialist copayment** \$50
- **Hospital (facility) coinsurance** 30%
- **Other coinsurance** 30%

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:

<i>Cost Sharing</i>	
Deductibles	\$1,870
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,170

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



Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service people with disabilities as well as free language services for people whose primary language is not English. Please contact the Customer Service number on the back of your ID card for assistance.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a las personas con discapacidades, así como servicios lingüísticos gratuitos para las personas cuyo idioma principal no es el inglés. Comuníquese con el número para servicio al cliente que aparece en el reverso de su tarjeta del seguro para obtener ayuda.

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