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: $5,000 Individual/$5,000 Family Member/$10,000 Family. Out-of-Network: $10,000 Individual/ $10,000 Family Member/$20,000 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 meets 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: $9,100 Individual/$9,100 Family Member/$18,200 Family. Out-of-Network: $18,200 Individual/ $18,200 Family Member/$36,400 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-billing 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.bluecrossnc.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	$25 copayment	30% coinsurance	None
	Specialist visit	$50 copayment	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge	No Charge	-You may have to pay for services that 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	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition	Tier 1 Drugs	$10 copayment	$10 copayment	-Prior authorization may be required or services will not be covered - Copayment applies to a 30-day
	Tier 2 Drugs	$10 copayment	$10 copayment	
	Tier 3 Drugs	$35 copayment	$35 copayment	

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.bluecrossnc.com/rxinfo**	Tier 4 Drugs	$45 copayment	$45 copayment	supply *See Prescription Drug section.
	Tier 5 Drugs	$50 copayment	$50 copayment	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$150/No IP Admission; 20% Coinsurance/With IP Admission	$150/No IP Admission; 20% Coinsurance/With IP Admission	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	30% coinsurance	-Prior authorization may be required or services will not be covered
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50/office visit; 20% coinsurance/ outpatient	30% coinsurance	-Prior authorization may be required or services will not be covered
	Inpatient services	20% coinsurance	30% coinsurance	-Prior authorization may be required or services will not be covered
	Office visits	20% coinsurance	30% coinsurance	-*See Family Planning section.

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	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	30% 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	30% coinsurance	-Prior authorization may be required or services will not be covered
	Rehabilitation services	20% coinsurance	30% coinsurance	-*See Therapies section -Limits do not apply to mental illness diagnoses.
	Habilitation services	20% coinsurance	30% coinsurance	-Habilitation services are combined with the Rehabilitation service limits listed above.
	Skilled nursing care	20% coinsurance	30% coinsurance	-Coverage is limited to 120 days . -Prior authorization may be required or services will not be covered
	Durable medical equipment	20% coinsurance	30% coinsurance	-Prior authorization may be required or services will not be covered -Limits may apply
	Hospice services	0% coinsurance	0% coinsurance	-Prior authorization may be required or services may not be covered
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Excluded Service
	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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Routine eye 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.)

- Chiropractic care
- Hearing aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care other than palliative or cosmetic.

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 on how 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**

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.

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

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	$5,000
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	$5,000
Copayments	$10
Coinsurance	$1,280
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,350**

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

The plan's overall deductible	$5,000
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	$450
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,790**

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

The plan's overall deductible	$5,000
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	$1,870
Copayments	$300
Coinsurance	$0
What isn't covered	
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.

BlueCross BlueShield of North Carolina

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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