




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/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 1-888-206-4697 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|---|--|
| What is the overall deductible? | In-Network: \$35 Individual / \$70 Family. Out-of-Network: \$70 Individual / \$140 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 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 <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? | Yes. \$35 for <u>prescription drug coverage</u> . There are no other specific <u>deductibles</u> . | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | In-Network: \$3,150 Individual / \$6,300 Family. Out-of-Network: \$6,300 Individual / \$12,600 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-billing</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> . |

| Important Questions | Answers | Why This Matters: |
|--|---|--|
| Will you pay less if you use a <u>network provider</u>? | Yes. See www.BlueCrossNC.com/FindADoc tor or call 1-888-206-4697 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 <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</u> office or clinic | Primary care visit to treat an injury or illness | \$10 copayment | 80% after deductible | None. |
| | <u>Specialist</u> visit | \$20 copayment | 80% after deductible | None. |
| | <u>Preventive care/screening/immunization</u> | No Charge | 30% after deductible | 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) | 50% after deductible | 80% after deductible | None. |
| | Imaging (CT/PET scans, MRIs) | 50% after deductible | 80% after deductible | <u>Prior authorization</u> 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/booklets

| 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 prescription drug coverage is available at www.BlueCrossNC.com/rxinfo | Tier 1 Drugs | \$10 copayment | \$10 copayment | <u>Prior authorization</u> may be required and coverage limits may apply. <u>Copayment</u> applies to a 30-day supply. *See <u>Prescription Drug Section</u> . |
| | Tier 2 Drugs | 50% after prescription drug deductible | 50% after prescription drug deductible | |
| | Tier 3 Drugs | 50% after prescription drug deductible | 50% after prescription drug deductible | |
| | Tier 4 Drugs | 50% after prescription drug deductible | 50% after prescription drug deductible | |
| | Tier 5 Drugs | 50% after prescription drug deductible | 50% after prescription drug deductible | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 50% after deductible | 80% after deductible | None. |
| | Physician/surgeon fees | 50% after deductible | 80% after deductible | None. |
| If you need immediate medical attention | <u>Emergency room care</u> | 50% after deductible | 50% after deductible | None. |
| | <u>Emergency medical transportation</u> | 50% after deductible | 50% after deductible | None. |
| | <u>Urgent care</u> | \$20 copayment | \$40 copayment | None. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 50% after deductible | 80% after deductible | <u>Prior authorization</u> may be required or services will not be covered. |
| | Physician/surgeon fees | 50% after deductible | 80% after deductible | None. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$10 copayment / office visit; 50% after deductible / outpatient | 80% after deductible | <u>Prior authorization</u> may be required or services will not be covered. |
| | Inpatient services | 50% after deductible | 80% after deductible | <u>Prior authorization</u> may be required or services will not be covered. |

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| 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 | 50% after deductible | 80% after deductible | Exceptions may apply. *See Family Planning section. |
| | Childbirth/delivery professional services | 50% after deductible | 80% after deductible | None. |
| | Childbirth/delivery facility services | 50% after deductible | 80% after deductible | <u>Prior authorization</u> 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> | 50% after deductible | 80% after deductible | <u>Prior authorization</u> may be required or services will not be covered. |
| | <u>Rehabilitation services</u> | \$20 copayment /office visit; 50% after deductible /outpatient | 80% after deductible | Combined 30 visits for physical / occupational therapy and chiropractic services. 30 visits for speech therapy. Visit limits do not apply to mental illness diagnoses. |
| | <u>Habilitation services</u> | \$20 copayment /office visit; 50% after deductible /outpatient | 80% after deductible | Combined 30 visits for physical / occupational therapy and chiropractic services. 30 visits for speech therapy. Visit limits do not apply to mental illness diagnoses. |
| | <u>Skilled nursing care</u> | 50% after deductible | 80% after deductible | Coverage is limited to 60 days. <u>Prior authorization</u> may be required or services will not be covered. |
| | <u>Durable medical equipment</u> | 50% after deductible | 80% after deductible | <u>Prior authorization</u> may be required or services will not be covered. Limits may apply. |
| | <u>Hospice services</u> | 50% after deductible | 80% after deductible | <u>Prior authorization</u> may be required or services may not be covered. |
| | If your child needs dental or eye care | Children's eye exam | No Charge | 30% after deductible |
| Children's glasses | | 50% no deductible | 50% no deductible | Limited to one pair of glasses or contacts. |
| Children's dental check-up | | No Charge | 30% after deductible | Limited to two dental cleanings. |

*For more information about limitations and exceptions, see [plan](#) or policy document at www.BlueCrossNC.com/booklets

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.)

- Abortion (Except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- 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.)

- Bariatric surgery
- 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: North Carolina Insurance Consumer Assistance Program at www.ncdoi.com/Smart or 1-855-408-1212 or contact Blue Cross NC at 1-888-206-4697 or www.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:

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: N.C. Department of Insurance 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, N.C. Department of Insurance, at 1201 Mail Service Center, Raleigh, NC 27699-1201, 1-855-408-1212 (toll free).

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? Not Applicable.

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 1-888-206-4697.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-206-4697.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-206-4697.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-206-4697.

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 | \$35 |
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) coinsurance | copayment 50% after deductible |
| ■ Other coinsurance | 50% |

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 | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$35 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$3,100 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,195 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|--|-----------------------------------|
| ■ The plan's overall deductible | \$35 |
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) coinsurance | copayment 50% after deductible |
| ■ Other coinsurance | 50% |

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 | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$70 |
| <u>Copayments</u> | \$300 |
| <u>Coinsurance</u> | \$2,000 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,390 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|--|-----------------------------------|
| ■ The plan's overall deductible | \$35 |
| ■ Specialist copayment | \$20 |
| ■ Hospital (facility) coinsurance | copayment 50% after deductible |
| ■ Other coinsurance | 50% |

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 | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$35 |
| <u>Copayments</u> | \$100 |
| <u>Coinsurance</u> | \$1,000 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,135 |

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.