



**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](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-877-275-9787 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                          | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | In-Network: \$500 Individual/\$500 Family Member/\$1,000 Family. Out-of-Network: \$1,000 Individual/\$1,000 Family Member/\$2,000 Family.                        | 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> .                                                                                                                                                 |
| <b>Are there services covered before you meet your deductible?</b> | 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 <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                             |
| <b>Are there other deductibles for specific services?</b>          | No.                                                                                                                                                              | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>What is the out-of-pocket limit for this plan?</b>              | In-Network: \$2,000 Individual/\$2,000 Family Member/\$4,000 Family. Out-of-Network: \$2,000 Individual/\$2,000 Family Member/\$4,000 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 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.                                                                                                                                                                                                                                                                |
| <b>What is not included in the out-of-pocket limit?</b>            | <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> .                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.bluecrossnc.com/FindADoctor">www.bluecrossnc.com/FindADoctor</a> or call 1-877-275-9787 for a list of <u>network providers</u> .    | This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 provider for the difference between the provider's charge and what your plan 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 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                    |
| <b>If you visit a health care provider's office or clinic</b>                                                                                      | Primary care visit to treat an injury or illness | \$25 <u>copayment</u>                        | 20% <u>coinsurance</u>                             | None                                                                                                                                                                                               |
|                                                                                                                                                    | <u>Specialist</u> visit                          | \$50 <u>copayment</u>                        | 20% <u>coinsurance</u>                             | None                                                                                                                                                                                               |
|                                                                                                                                                    | <u>Preventive care/screening/immunization</u>    | No Charge                                    | 20% <u>coinsurance</u>                             | -You may have to pay for services that aren't preventive. 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 |
| <b>If you have a test</b>                                                                                                                          | <u>Diagnostic test</u> (x-ray, blood work)       | 10% <u>coinsurance</u>                       | 20% <u>coinsurance</u>                             | None                                                                                                                                                                                               |
|                                                                                                                                                    | Imaging (CT/PET scans, MRIs)                     | 10% <u>coinsurance</u>                       | 20% <u>coinsurance</u>                             | -Prior authorization may be required or services will not be covered                                                                                                                               |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b><u>prescription drug coverage</u></b> is available at | Tier 1 Drugs                                     | \$10 <u>copayment</u>                        | \$10 <u>copayment</u>                              | -Prior authorization may be required or services will not be covered - Copayment applies to a 30-day supply -For Infertility dosage limits apply - *See <u>Prescription Drug</u> section.          |
|                                                                                                                                                    | Tier 2 Drugs                                     | \$30 <u>copayment</u>                        | \$30 <u>copayment</u>                              |                                                                                                                                                                                                    |
|                                                                                                                                                    | Tier 3 Drugs                                     | \$50 <u>copayment</u>                        | \$50 <u>copayment</u>                              |                                                                                                                                                                                                    |
|                                                                                                                                                    | Tier 4 Drugs                                     | \$50 <u>copayment</u>                        | \$50 <u>copayment</u>                              |                                                                                                                                                                                                    |

| Common Medical Event                                                             | Services You May Need                          | What You Will Pay                                        |                                                          | Limitations, Exceptions, & Other Important Information               |
|----------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------|
|                                                                                  |                                                | Network Provider<br>(You will pay the least)             | Out-of-Network Provider<br>(You will pay the most)       |                                                                      |
| <a href="http://www.bluecrossnc.com/rxinfo">www.bluecrossnc.com/rxinfo</a>       |                                                |                                                          |                                                          |                                                                      |
| <b>If you have outpatient surgery</b>                                            | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u>                                   | 20% <u>coinsurance</u>                                   | None                                                                 |
|                                                                                  | Physician/surgeon fees                         | 10% <u>coinsurance</u>                                   | 20% <u>coinsurance</u>                                   | None                                                                 |
| <b>If you need immediate medical attention</b>                                   | <u>Emergency room care</u>                     | \$300/No IP Admission; 10% Coinsurance/With IP Admission | \$300/No IP Admission; 10% Coinsurance/With IP Admission | None                                                                 |
|                                                                                  | <u>Emergency medical transportation</u>        | 10% <u>coinsurance</u>                                   | 10% <u>coinsurance</u>                                   | None                                                                 |
|                                                                                  | <u>Urgent care</u>                             | \$50 <u>copayment</u>                                    | \$100 <u>copayment</u>                                   | None                                                                 |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)             | 10% <u>coinsurance</u>                                   | 20% <u>coinsurance</u>                                   | -Prior authorization may be required or services will not be covered |
|                                                                                  | Physician/surgeon fees                         | 10% <u>coinsurance</u>                                   | 20% <u>coinsurance</u>                                   | None                                                                 |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                            | \$10/office visit; 10% <u>coinsurance</u> /outpatient    | 20% <u>coinsurance</u>                                   | -Prior authorization may be required or services will not be covered |
|                                                                                  | Inpatient services                             | 10% <u>coinsurance</u>                                   | 20% <u>coinsurance</u>                                   | -Prior authorization may be required or services will not be covered |
|                                                                                  | Office visits                                  | 10% <u>coinsurance</u>                                   | 20% <u>coinsurance</u>                                   | -*See Family Planning section.                                       |

| Common Medical Event                                                  | Services You May Need                     | What You Will Pay                                 |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                   |
|-----------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                           | Network Provider<br>(You will pay the least)      | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                          |
| <b>If you are pregnant</b>                                            | Childbirth/delivery professional services | 10% <u>coinsurance</u>                            | 20% <u>coinsurance</u>                             | None                                                                                                                                                                                     |
|                                                                       | Childbirth/delivery facility services     | 10% <u>coinsurance</u>                            | 20% <u>coinsurance</u>                             | -Prior authorization may be required or services will not be covered                                                                                                                     |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>                   | 10% <u>coinsurance</u>                            | 20% <u>coinsurance</u>                             | -Prior authorization may be required or services will not be covered                                                                                                                     |
|                                                                       | <u>Rehabilitation services</u>            | \$50 copayment/office; 10% coinsurance/outpatient | 20% <u>coinsurance</u>                             | -*See Therapies section -Combined 60 visits for physical/occupational therapy and chiropractic services.-30 visits for speech therapy., visits with mental illness diagnoses don't apply |
|                                                                       | <u>Habilitation services</u>              | \$50 copayment/office; 10% coinsurance/outpatient | 20% <u>coinsurance</u>                             | - <u>Habilitation services</u> are combined with the <u>Rehabilitation service</u> limits listed above.                                                                                  |
|                                                                       | <u>Skilled nursing care</u>               | 10% <u>coinsurance</u>                            | 20% <u>coinsurance</u>                             | -Coverage is limited to 60 days . - Prior authorization may be required or services will not be covered                                                                                  |
|                                                                       | <u>Durable medical equipment</u>          | 10% <u>coinsurance</u>                            | 20% <u>coinsurance</u>                             | -Prior authorization may be required or services will not be covered -Limits may apply                                                                                                   |
|                                                                       | <u>Hospice services</u>                   | 10% <u>coinsurance</u>                            | 20% <u>coinsurance</u>                             | -Prior authorization may be required or services may not be covered                                                                                                                      |

| Common Medical Event                          | Services You May Need      | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information |
|-----------------------------------------------|----------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                                               |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                        |
| <b>If your child needs dental or eye care</b> | 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
- Long-term care
- Cosmetic surgery
- Routine eye care (Adult)
- Dental 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
- Infertility treatment
- Routine foot care other than palliative or cosmetic.
- 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](http://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](http://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](http://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](http://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, kwijijigo 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   | \$500 |
| ■ Specialist copayment            | \$50  |
| ■ Hospital (facility) coinsurance | 10%   |
| ■ Other coinsurance               | 10%   |

**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                       | \$500          |
| Copayments                        | \$10           |
| Coinsurance                       | \$1,090        |
| What isn’t covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,660</b> |

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

|                                   |       |
|-----------------------------------|-------|
| ■ The plan’s overall deductible   | \$500 |
| ■ Specialist copayment            | \$50  |
| ■ Hospital (facility) coinsurance | 10%   |
| ■ Other coinsurance               | 10%   |

**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                       | \$500          |
| Copayments                        | \$450          |
| Coinsurance                       | \$80           |
| What isn’t covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,050</b> |

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

|                                   |       |
|-----------------------------------|-------|
| ■ The plan’s overall deductible   | \$500 |
| ■ Specialist copayment            | \$50  |
| ■ Hospital (facility) coinsurance | 10%   |
| ■ Other coinsurance               | 10%   |

**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                       | \$500        |
| Copayments                        | \$310        |
| Coinsurance                       | \$140        |
| What isn’t covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$950</b> |

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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