



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 <u>deductible</u>? | In-Network: \$1,250 Individual/\$3,125 Family. Out-of-Network: \$3,125 Individual/\$7,800 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 <u>deductible</u>? | Yes. Preventive care and most services that may require a copayment. | 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 <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | In-Network: \$4,000 Individual/\$10,000 Family. Out-of-Network: \$10,000 Individual/\$25,000 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 <u>out-of-pocket limit</u>? | <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> . |
| Will you pay less if you use a <u>network provider</u>? | 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-</u> |

| | | |
|--|-----|--|
| | | <u>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 | \$30 <u>copayment</u> | 40% <u>coinsurance</u> | None |
| | <u>Specialist</u> visit | \$50 <u>copayment</u> | 40% <u>coinsurance</u> | None |
| | <u>Preventive care/screening/immunization</u> | No Charge | 40% <u>coinsurance</u> | -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) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -Prior authorization may be required or services will not be covered |
| | Generic Drugs | \$15 copayment | Up to 90 days \$37.50 | Non-preferred pharmacies will apply a \$5 additional copayment. Non-preferred pharmacies include, but are not limited to, CVS, Novant Health and Target. |
| | Preferred Drugs | \$30 copayment | Up to 90 days \$75 | |

| 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 Drugs | \$60 copayment | Up to 90 days \$150 | Maintenance medications are limited two grace fills at retail. If not moved to the OptumRx Home Delivery program there will be an additional copay at the retail pharmacy. |
| | Specialty Drugs | 10% coinsurance for up to a 30 day supply, minimum of \$50 up to maximum of \$100 | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | \$200 <u>copayment</u> | \$200 <u>copayment</u> | None |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 20% <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) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -Prior authorization may be required or services will not be covered |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$30 copayment | 30% <u>coinsurance</u> | Administered by Carolina Behavioral Health Alliance. \$1,000 out of pocket maximum for behavioral health; separate from medical/Rx MOOP |
| | Inpatient services | No charge | 30% <u>coinsurance</u> | |
| If you are pregnant | Office visits | \$30 <u>copayment</u> | 40% <u>coinsurance</u> | -This benefit applies in limited situations.*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) | |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 40% <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> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -Prior authorization may be required or services will not be covered |
| | <u>Rehabilitation services</u> | \$50 <u>copayment</u> | 40% <u>coinsurance</u> | -*See Therapies section |
| | <u>Habilitation services</u> | \$50 <u>copayment</u> | 40% <u>coinsurance</u> | - <u>Habilitation services</u> are combined with the <u>Rehabilitation service</u> limits listed above. |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -Coverage is limited to 90 days . - Prior authorization may be required or services will not be covered |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -Prior authorization may be required or services will not be covered -Limits may apply |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -Prior authorization may be required or services will not be covered |
| If your child needs dental or eye care | Children's eye exam | \$30 <u>copayment</u> | 40% <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
- 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 eye care (Adult)
- 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 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.

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) | Managing Joe’s Type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | Mia’s Simple Fracture (in-network emergency room visit and follow up care) |
|--|---|--|

| | | | | | |
|---|---------|---|---------|---|---------|
| ■ The <u>plan’s</u> overall <u>deductible</u> | \$1,250 | ■ The <u>plan’s</u> overall <u>deductible</u> | \$1,250 | ■ The <u>plan’s</u> overall <u>deductible</u> | \$1,250 |
| ■ <u>Specialist copayment</u> | \$50 | ■ <u>Specialist copayment</u> | \$50 | ■ <u>Specialist copayment</u> | \$50 |
| ■ <u>Hospital (facility) coinsurance</u> | 20% | ■ <u>Hospital (facility) coinsurance</u> | 20% | ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other coinsurance</u> | 20% | ■ <u>Other coinsurance</u> | 20% | ■ <u>Other coinsurance</u> | 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*)

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*)

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 | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
|---------------------------|-----------------|---------------------------|----------------|---------------------------|----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,300 |
| Copayments | \$0 |
| Coinsurance | \$2,000 |
| What isn’t covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,400 |

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,300 |
| Copayments | \$300 |
| Coinsurance | \$600 |
| What isn’t covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,200 |

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,300 |
| Copayments | \$300 |
| Coinsurance | \$100 |
| What isn’t covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,700 |

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

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 languages 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@bcbnsnc.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.

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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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.

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ATTENTION: 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.

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PAUNAWA: Kungnagsasalita 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.

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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.

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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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