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 thepremium) 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 acopy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: $750 Individual/$1,875 Family. Out-of-Network: $1,875 Individual/$4,675 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 et 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: $3,000 Individual/$7,500 Family. Out-of-Network: $7,500 Individual/$18,750 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, prescription drugs, 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 lessif you use a network provider?	Yes. See www.bcbsnc.com/FindADoctor or call 1-877-275-9787 for a list of network providers.	This plan uses a provide rnetwork. 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 willpay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copayment	30% coinsurance	None
	Specialist visit	$50 copayment	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge	30% coinsurance	-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)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	-Prior authorization may be required or services will not be covered
If you need drugs to treat your illness or condition	Generic Drugs	$15 copayment	Up to 90 days $37.50	Administered by OptumRx. Non-preferred pharmacies will apply a $5 additional copayment. Non-preferred pharmacies include, but are not limited to, CVBS, 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 willpay the most)	
If you need drugs to treat your illness or condition	Non-Preferred Drugs	$60 copayment	Not Covered	Maintenance medications are limited to 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)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copayment	$200 copayment	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$50 copayment	$50 copayment	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	-Prior authorization may be required or services will not be covered
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	-Prior Authorization may be required
	Inpatient services	Not Covered	Not Covered	-Precertification required
If you are pregnant	Office visits	$30 copayment	30% coinsurance	-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	10% coinsurance	30% coinsurance	None
	Childbirth/delivery facility services	10% 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	10% coinsurance	30% coinsurance	-Prior authorization may be required or services will not be covered
	Rehabilitation services	10% coinsurance	30% coinsurance	-*See Therapies section
	Habilitation services	10% coinsurance	30% coinsurance	-Habilitation services are combined with the Rehabilitation service limits listed above.
	Skilled nursing care	10% coinsurance	30% coinsurance	-Coverage is limited to 90 days . -Prior authorization may be required or services will not be covered
	Durable medical equipment	10% coinsurance	30% coinsurance	-Prior authorization may be required or services will not be covered -Limits may apply
	Hospice services	10% coinsurance	30% coinsurance	-Prior authorization may be required or services will not be covered
If your child needs dental or eye care	Children's eye exam	$30 copayment	30% coinsurance	-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
- Cosmeticsurgery
- Dental care(Adult)
- Long-term care
- Routine FootCare
- Weight lossprograms

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 outsidethe U.S.
- Private duty nursing
- Routine eye care(Adult)

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 optionsmay 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 documentsalso provide complete information on how to submit a claim, appeal, or a grievance for any reason to yourplan. For more informationabout 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 taxcredit.

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 Tagalogtumawag 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 theplan. 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 overalldeductible** $750
- **Specialist copayment** $50
- **Hospital (facility)coinsurance** 10%
- **Other coinsurance** 10%

This EXAMPLE event includesservices like:
Specialist office visits(*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and bloodwork*)
Specialistvisit *(anesthesia)*

Total Example Cost $12,700

Inthis example, Peg would pay:

Cost Sharing	
Deductibles	$800
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,000**

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

- **The plan's overalldeductible** $750
- **Specialist copayment** $50
- **Hospital (facility)coinsurance** 10%
- **Other coinsurance** 10%

This EXAMPLE event includesservices like:
Primary care physician office visits (*including diseaseeducation)*
Diagnostic tests*(blood work)*
Prescription drugs
Durable medical equipment*(glucose meter)*

Total Example Cost $5,600

Inthis example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,400**

Mia's SimpleFracture
(in-network emergencyroom visit and follow up care)

- **The plan's overalldeductible** $750
- **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 *(physicaltherapy)*

Total Example Cost $2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$800
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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

BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides:

- Free aids and services to people with disabiliti es to communicate effectively with us, such as: qualified interpreters and/or w ritten information in other formats (large pr int , accessible electronic formats, etc.)
- Free languageservices to people whose primary language is not English, such as: qualified interprete rs 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 grievancew ith:

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-m ail : civ ilrightscoordinator @b cbsnc.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, Ethi cs & Corporate Policy Office is available to help you. You can also file a civil rights complaint w ith the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Comp laint Portal, available at

Online: https://ocrportal.hhs.gov/ocr/smartscreen/m ain .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-comp laintI inde x.html

This notice and/or attachments may have import ant 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 numb er on t he back of your member ID card.

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Discrimination is Against the Law

Blue Cross NC complies with applicable federal civil rights law s 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.

BlueCross BlueShield of North Carolina

Multi-language Interpreter Services

ATTEN TION: 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 IDcard.

ATENCION: Si habla otro idioma, tiene a su disposici6n servicios gratuitos de asistencia linguistica. Llame a Servicio de Atenci6n al Cliente al numero de telefono para personas con problemas auditivos (TTY) que figura al dorso de su tarjeta de identificaci6n.

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ATTENTIONo: si vous parlez une autre langue, des services d'aide linguistique vous sont proposes gratuitement. Contactez le service clients au numero figurant au dos de votre carte de membre.

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PAUNAWA: Kungnagsasalita ka ng ibang lengguwahe, maaari kanggumamit 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 Verfogung. Rufen Sie die Nummer des Kundenservices oder von TTY an, die auf der Ruckseite 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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