




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](http://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:
<b>What is the overall <u>deductible</u>?</b>	In-Network: \$0 Individual / \$0 Family. Out-of-Network: \$500 Individual / \$1,000 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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	In-Network: \$700 Individual / \$1,400 Family. Out-of-Network: Not Applicable.	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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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 <a href="http://www.bluecrossnc.com/FindADoctor">www.bluecrossnc.com/FindADoctor</a> 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	\$5 copayment	70% after deductible	First three visits covered at no charge.
	<u>Specialist</u> visit	\$20 copayment	70% 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)	40% after deductible	70% after deductible	None.
	Imaging (CT/PET scans, MRIs)	40% after deductible	70% after deductible	Prior authorization 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](http://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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.bluecrossnc.com/rxinfo">www.bluecrossnc.com/rxinfo</a>	Tier 1 Drugs	\$4 copayment	\$4 copayment	Prior authorization may be required and coverage limits may apply. Copayment applies to a 30-day supply. *See <a href="#">Prescription Drug Section</a> .
	Tier 2 Drugs	\$10 copayment	\$10 copayment	
	Tier 3 Drugs	\$20 copayment	\$20 copayment	
	Tier 4 Drugs	\$80 copayment	\$80 copayment	
	Tier 5 Drugs	50%	50%	
	Tier 6 Drugs	50%	50%	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% after deductible	70% after deductible	None.
	Physician/surgeon fees	40% after deductible	70% after deductible	None.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	40% after deductible	40% after deductible	None.
	<u>Emergency medical transportation</u>	40% after deductible	40% after deductible	None.
	<u>Urgent care</u>	\$20 copayment	\$20 copayment	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	40% after deductible	70% after deductible	Prior authorization may be required or services will not be covered.
	Physician/surgeon fees	40% after deductible	70% after deductible	None.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$5 copayment / office visit; 40% after deductible / outpatient	70% after deductible	First three office visits covered at no charge. Prior authorization may be required or services will not be covered.
	Inpatient services	40% after deductible	70% after deductible	Prior authorization 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](http://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)	
<b>If you are pregnant</b>	Office visits	\$5 copayment	70% after deductible	This benefit applies in limited situations. *See Family Planning section.
	Childbirth/delivery professional services	40% after deductible	70% after deductible	None.
	Childbirth/delivery facility services	40% after deductible	70% after deductible	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>	40% after deductible	70% after deductible	Prior authorization may be required or services will not be covered.
	<u>Rehabilitation services</u>	\$20 copayment	70% after deductible	Combined 30 visits for physical / occupational therapy and chiropractic services. 30 visits for speech therapy.
	<u>Habilitation services</u>	\$20 copayment	70% after deductible	Combined 30 visits for physical / occupational therapy and chiropractic services. 30 visits for speech therapy.
	<u>Skilled nursing care</u>	40% after deductible	70% after deductible	Coverage is limited to 60 days. Prior authorization may be required or services will not be covered.
	<u>Durable medical equipment</u>	40% after deductible	70% after deductible	Prior authorization may be required or services will not be covered. Limits may apply.
	<u>Hospice services</u>	40% after deductible	70% after deductible	Prior authorization may be required or services may not be covered.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	30% after deductible	Limited to one eye exam.
	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](http://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)
- Routine foot care
- 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 up to age 22
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- 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: North Carolina Insurance Consumer Assistance Program at [www.ncdoi.com/Smart](http://www.ncdoi.com/Smart) or 1-855-408-1212 or contact Blue Cross NC at 1-888-206-4697 or [BlueConnectNC.com](http://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](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: 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)

■ <b>The plan's overall deductible</b>	\$0
■ <b>Specialist copayment</b>	\$20
■ <b>Hospital (facility) coinsurance</b>	40% after copayment deductible
■ <b>Other coinsurance</b>	40%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$5
Coinsurance	\$695
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$760</b>

### Managing Joe's Type 2 Diabetes

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

■ <b>The plan's overall deductible</b>	\$0
■ <b>Specialist copayment</b>	\$20
■ <b>Hospital (facility) coinsurance</b>	40% after copayment deductible
■ <b>Other coinsurance</b>	40%

#### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$405
Coinsurance	\$295
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$720</b>

### Mia's Simple Fracture

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

■ <b>The plan's overall deductible</b>	\$0
■ <b>Specialist copayment</b>	\$20
■ <b>Hospital (facility) coinsurance</b>	40% after copayment deductible
■ <b>Other coinsurance</b>	40%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$104
Coinsurance	\$596
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$700</b>

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 language 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@bcbsnc.com](mailto:civilrightscoordinator@bcbsnc.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.

注意：他の言語を話す方は、言語支援サービスを無料でご利用いただけます。

顧客サービスにお電話いただくか、会員IDカードの裏面にあるTTYサービスをご利用ください。

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số Dịch vụ khách hàng hoặc TTY trên mặt sau thẻ ID thành viên của bạn.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.  
가입자 ID 카드 뒷면에 있는 고객 서비스 혹은 TTY 번호로 전화해 주십시오.

**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.

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم خدمة العملاء أو رقم الهاتف النصي الموضح على ظهر بطاقة هوية العضو.

**LUS CEEB TOOM:** Yog tias koj hais lus Hmoob, , peb muaj kev pab txhais lus pub dawb rau koj. Hu rau Customer Service tus xov tooj los yog tus xov tooj TTY rau cov neeg tsis hnov lus zoo uas nyob sab tom qab koj daim npav ID.

**ВНИМАНИЕ:** Если вы говорите на другом языке, то вам доступны бесплатные услуги перевода.  
Позвоните в Отдел обслуживания по номеру, указанному на обратной стороне вашей идентификационной карточки участника.

**PAUNAWA:** Kung nagsasalita 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.

સુચના: જો તમે ગુજરાતી બોલતા હોવ તો તમારા માટે ભાષા સેવાઓ નિ:શુલ્ક ઉપલબ્ધ છે. તમારા સ ચપલ ઓપન રની (આઈ.ડી) પાછળની બાજુ પર આપેલ ગરહક સેવાઓના નંબર અથવા TTY નંબર પર કોલ કરો.

ចំណាំ: ប្រសិនបើប្រាកដកម្មនិយាយជាភាសាខ្មែរ បសវាកម្មជំនួយម្តុំភាសាមានលក្ខណៈសេរីសម្រាប់ប្រាកដកម្មបោលមិនគិតថ្លៃ។ សូមប្រើលេខសម្របសម្រួលទូរស័ព្ទលើខាងក្រោយសមាជិកកម្មសម្រាប់ប្រាកដកម្ម។

**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.

ເຂົ້າຊາບ: ຖ້າທ່ານເວົ້າພາສາອື່ນ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການລູກຄ້າຫລື ເບີ TTY ຢູ່ດ້ານຫຼັງບັດປະຈຳຕົວຂອງທ່ານ.

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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