



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, [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- \$1,000 Individual/\$2,000 Family Total. Out-of-Network- \$2,000 Individual/\$4,000 Family Total. Doesn't apply to In-Network preventive care. <u>Coinsurance</u> and <u>copayments</u> do not apply to the <u>deductible</u> .	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 services</u> .	For example, this plan covers certain <u>preventive services</u> without cost sharing and before you meet your deductible. See a list of covered preventive services 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- \$3,000 Individual/\$6,000 Family Total. Out-of-Network- \$6,000 Individual/\$12,000 Family Total.	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-billed</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.bcbsnc.com/FindADoctor">www.bcbsnc.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 (You will pay the least)	Out-of-Network Provider (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	\$30/visit	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$50/visit	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	-You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services 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>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-Prior review and certification of services may be required or services will not be covered
<b>If you need drugs to treat your illness or condition</b>	Tier 1 Drugs	\$10/prescription	\$10/prescription	- * See <u>Prescription Drug</u> section. - For Infertility dosage limits apply - Minimum of \$0 in <u>coinsurance</u> but no more than \$150 for tier 5 drugs
	Tier 2 Drugs	\$10/prescription	\$10/prescription	
	Tier 3 Drugs	\$35/prescription	\$35/prescription	

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)	
More information about <b>prescription drug coverage</b> is available at <a href="http://www.bcbsnc.com/rxinfo">www.bcbsnc.com/rxinfo</a>	Tier 4 Drugs	\$55/prescription	\$55/prescription	
	Tier 5 Drugs	25% <u>coinsurance</u> /prescription	25% <u>coinsurance</u>	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$250/visit	\$250/visit	None
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$50/visit	\$50/visit	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-Prior review and certification of services may be required or services will not be covered
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30/office visit; 10% <u>coinsurance</u> / outpatient	30% <u>coinsurance</u>	-Prior review and certification of services may be required or services will not be covered
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-Prior review and certification of services may be required or services will not be covered

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	\$30/visit	30% <u>coinsurance</u>	-*See Family planning section. - <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-No coverage for maternity for dependent children.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-Precertification may be required
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-Prior review and certification of services may be required or services will not be covered
	<u>Rehabilitation services</u>	\$50/visit	30% <u>coinsurance</u>	-*See Therapies section -30 visits/benefit period includes PT/OT/Chiropractic Care. -30 visits/benefit period Speech Therapy - \$40,000 max/benefit period for Adaptive Behavior Treatment (18 and younger)
	<u>Habilitation services</u>	\$50/visit	30% <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>	30% <u>coinsurance</u>	-Coverage is limited to 60 days per benefit period. -Prior review and certification of services may be required or services will not be covered

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)	
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-Prior review and certification of services may be required or services will not be covered -Limits may apply
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-Precertification may be required
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not Covered	-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, respite care, rest cures
- Cosmetic surgery and services
- 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. (PPO). Coverage provided outside the United States. See [www.bluecrossnc.com](http://www.bluecrossnc.com)
- 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 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**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

#### **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 número que aparece al respaldo de su tarjeta del seguro.

Tagalog (Tagalog): Para matulungan sa Tagalog, tawagan ang numerong nasa likuran ng insurance card.

Chinese (中文): 如需國語或廣東話協助，請致電您保險卡背面的電話號碼。

Navajo (Dine): Diné bizaad bee shiká'adoowoł nínzingo kwoji' hólne', naaltsoos áłts'ísí nantinígíí bine'déé' binámboo bikáá'.

-----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	\$1,000
■ 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** **\$12,800**

#### In this example, Peg would pay:

##### Cost Sharing

Deductibles	\$1,000
Copayments	\$30
Coinsurance	\$1,100

##### What isn't covered

Limits or exclusions	\$60
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**The total Peg would pay is** **\$2,200**

### Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,000
■ 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** **\$7,400**

#### In this example, Joe would pay:

##### Cost Sharing

Deductibles	\$1,000
Copayments	\$700
Coinsurance	\$100

##### What isn't covered

Limits or exclusions	\$60
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**The total Joe would pay is** **\$1,900**

### Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ 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** **\$1,900**

#### In this example, Mia would pay:

##### Cost Sharing

Deductibles	\$1,000
Copayments	\$200
Coinsurance	\$50

##### What isn't covered

Limits or exclusions	\$0
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**The total Mia would pay is** **\$1,300**

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





# Non-Discrimination and Accessibility Notice

## Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina ("BCBSNC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

- BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

### BCBSNC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
- If you need these services, contact Customer Service **1-888-206-4697**, TTY and TDD, call **1-800-442-7028**.
- If you believe that BCBSNC 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:
  - BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone **919-765-1663**, Fax **919-287-5613**, TTY **1-888-291-1783** [civilrightscordinator@bcbsnc.com](mailto:civilrightscordinator@bcbsnc.com)
- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, 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 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **1-800-368-1019, 800-537-7697** (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

- This Notice and/or attachments may have important information about your application or coverage through BCBSNC. 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. Call Customer Service **1-888-206-4697**.





**ATTENTION:** If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-206-4697 (TTY: 1-800-442-7028).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-206-4697 (TTY: 1-800-442-7028).

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。請致電 1-888-206-4697 (TTY : 1-800-442-7028)。

**CHÚ Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-206-4697 (TTY: 1-800-442-7028).

주의: 한글어체를 사용하여 주시기 바랍니다.

1-888-206-4697 (TTY: 1-800-442-7028)번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-206-4697 (ATS : 1-800-442-7028).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم الميرقة الكاتبة: 1-888-206-4697. الميرقة الكاتبة: 1-800-442-7028.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-206-4697 (TTY: 1-800-442-7028).

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.  
Звоните 1-888-206-4697 (телетайп: 1-800-442-7028).

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-206-4697 (TTY: 1-800-442-7028).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:સુદ્ધ ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-206-4697 (TTY: 1-800-442-7028).

ចំណាំ: ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មនឹងផ្ញើស្នើសុំការសាមាញ់ជូនសមាជិកដែលបានបង់ប្រាក់រួចរាល់។ សូមទំនាក់ទំនងតាមរយៈលេខ: 1-888-206-4697 (TTY: 1-800-442-7028)។

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-206-4697 (TTY: 1-800-442-7028).

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-206-4697 (TTY: 1-800-442-7028) पर कॉल करें।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີໄວ້ອນໃຫ້ທ່ານ. ໂທ 1-888-206-4697 (TTY: 1-800-442-7028).

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-888-206-4697  
(TTY: 1-800-442-7028) まで、お電話にてご連絡ください。