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 deductible?	In-Network: $1,000 Individual/$2,000 Family. Out-of-Network: $2,000 Individual/$4,000 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 yet 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/$6,000 Family. Out-of-Network: $6,000 Individual/$12,000 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, 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 less if you use a network provider?	Yes. See www.bluecrossnc.com/FindADoctor or call 1-877-275-9787 for a list of network providers.	This plan uses a provider network. 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 will pay 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	Not Covered	-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 More information about **prescription drug coverage** is available at	Tier 1 Drugs	$10 copayment	$10 copayment	-Prior authorization may be required or services will not be covered -Copayment applies to a 30-day supply -For Infertility dosage limits apply - *See Prescription Drug section.
	Tier 2 Drugs	$10 copayment	$10 copayment	
	Tier 3 Drugs	$35/prescription	$35/prescription	
	Tier 4 Drugs	$55 copayment	$55 copayment	

*For more information about limitations and exceptions, see plan or policy document at www.bluecrossnc.com

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 wil pay the most)	
www.bluecrossnc.com/rxinfo	Tier 5 Drugs	25% coinsurance	25% coinsurance	
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	$250 copayment	$250 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 wil not be covered
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10/office visit; 10% coinsurance/ outpatient	30% coinsurance	-Prior authorization may be required or services wil not be covered
	Inpatient services	10% coinsurance	30% coinsurance	-Prior authorization may be required or services wil not be covered
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 wil 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 wil 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 wil not be covered
	Rehabilitation services	$50 copayment	30% coinsurance	-*See Therapies section -Combined 30 visits for physical/occupational therapy and chiropractic services.-30 visits for speech therapy. - $40,000 max/benefit period for Adaptive Behavior Treatment (up to age 19).
	Habilitation services	$50 copayment	30% coinsurance	-Habilitation services are combined with the Rehabilitation service limits listed above.
	Skilled nursing care	10% coinsurance	30% coinsurance	-Coverage is limited to 60 days . - Prior authorization may be required or services wil not be covered
	Durable medical equipment	10% coinsurance	30% coinsurance	-Prior authorization may be required or services wil not be covered -Limits may apply
	Hospice services	10% coinsurance	30% coinsurance	-Prior authorization may be required or services wil 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 wil pay the most)	
If your child needs dental or eye care	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
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- 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 dutynursing
- 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 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 thatcan helpif youhave a complaint against your plan for a denial of aclaim. Thiscomplaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits youwill 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

*For more information about limitations and exceptions, see plan or policy document at www.bluecrossnc.com

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, 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 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 plan's overall deductible**	$1,000	■ **The plan's overall deductible**	$1,000	■ **The plan's overall deductible**	$1,000
■ **Specialist copayment**	$50	■ **Specialist copayment**	$50	■ **Specialist copayment**	$50
■ **Hospital (facility) coinsurance**	10%	■ **Hospital (facility) coinsurance**	10%	■ **Hospital (facility) coinsurance**	10%
■ **Other coinsurance**	10%	■ **Other coinsurance**	10%	■ **Other coinsurance**	10%
This EXAMPLE event includes services like:		**This EXAMPLE event includes services like:**		**This EXAMPLE event includes services like:**	
Specialist office visits *(prenatal care)*		Primary care physician officevisits *(including disease education)*		Emergency room care *(including medical supplies)*	
Childbirth/Delivery Professional Services		Diagnostic tests *(blood work)*		Diagnostic test *(x-ray)*	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment *(crutches)*	
Diagnostic tests *(ultrasounds and blood work)*		Durable medical equipment *(glucose meter)*		Rehabilitation services *(physical therapy)*	
Total Example Cost	**$12,700**	**Total Example Cost**	**$5,600**	**Total Example Cost**	**$2,800**

Inthis example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$1,040
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,110**

Inthis example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$500
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,550**

In this example, Miawould pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$300
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,390**

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

BlueCross BlueShield of North Carolina

NON-DISCRIMINATION AND ACCESSIBILITYNOTICE

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 inother formats (large print, audio, accessible electronic formats, other formats.)
+ 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, contact:

Customer Service
Call: 1-888-206-4697, 1-800-442-7028 (TTY and TDD)

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

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.hh s.gov/ci vil-ri ghts/filing-a- complai nt/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. Call CustomerService: 1-888-206-4697.

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.

BlueCross BlueShield of North Carolina

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: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 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 1-888-206-4697. المبرقة 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).

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

ចំណាំ៖ ប្រសិនបើអ្នកនិយាយជាភាសាខ្មែរ
សេវាកម្មជំនួយផ្នែកភាសាមានសម្រាប់អ្នកដោយមិនគិតថ្លៃ 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 हिंदी 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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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。