




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: \$2,500 Individual / \$5,000 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: \$7,250 Individual / \$14,500 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.                                                                                                                                                                                                                                          |
| <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:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Will you pay less if you use a <u>network provider</u>?</b>   | Yes. See <a href="http://www.BlueCrossNC.com/FindADoc">www.BlueCrossNC.com/FindADoc</a> tor 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. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b> | 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                           |
| <b>If you visit a health care <u>provider's</u> office or clinic</b> | Primary care visit to treat an injury or illness | \$50 copayment                               | Not Covered                                        | First three visits covered at no charge.                                                                                                                                                                  |
|                                                                      | <u>Specialist</u> visit                          | \$100 copayment                              | Not Covered                                        | None.                                                                                                                                                                                                     |
|                                                                      | <u>Preventive care/screening/immunization</u>    | No Charge                                    | Not Covered                                        | 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. |
| <b>If you have a test</b>                                            | <u>Diagnostic test</u> (x-ray, blood work)       | 50% after deductible                         | Not Covered                                        | None.                                                                                                                                                                                                     |
|                                                                      | Imaging (CT/PET scans, MRIs)                     | 50% after deductible                         | Not Covered                                        | <u>Prior authorization</u> 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                          |
| <b>If you need drugs to treat your illness or condition</b><br>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                                   | \$10 copayment                               | Not Covered                                        | <u>Prior authorization</u> may be required and coverage limits may apply. *See <u>Prescription Drug Section</u> .        |
|                                                                                                                                                                                                                    | Tier 2 Drugs                                   | 50% after deductible                         | Not Covered                                        |                                                                                                                          |
|                                                                                                                                                                                                                    | Tier 3 Drugs                                   | 50% after deductible                         | Not Covered                                        |                                                                                                                          |
|                                                                                                                                                                                                                    | Tier 4 Drugs                                   | 50% after deductible                         | Not Covered                                        |                                                                                                                          |
|                                                                                                                                                                                                                    | Tier 5 Drugs                                   | 50% after deductible                         | Not Covered                                        |                                                                                                                          |
|                                                                                                                                                                                                                    | Tier 6 Drugs                                   | 50% after deductible                         | Not Covered                                        |                                                                                                                          |
| <b>If you have outpatient surgery</b>                                                                                                                                                                              | Facility fee (e.g., ambulatory surgery center) | 50% after deductible                         | Not Covered                                        | None.                                                                                                                    |
|                                                                                                                                                                                                                    | Physician/surgeon fees                         | 50% after deductible                         | Not Covered                                        | None.                                                                                                                    |
| <b>If you need immediate medical attention</b>                                                                                                                                                                     | <u>Emergency room care</u>                     | 50% after deductible                         | 50% after deductible                               | None.                                                                                                                    |
|                                                                                                                                                                                                                    | <u>Emergency medical transportation</u>        | 50% after deductible                         | 50% after deductible                               | None.                                                                                                                    |
|                                                                                                                                                                                                                    | <u>Urgent care</u>                             | \$100 copayment                              | Not Covered                                        | You pay \$100 copayment when visiting any Urgent Care provider outside of the Blue Home with Novant Health product area. |
| <b>If you have a hospital stay</b>                                                                                                                                                                                 | Facility fee (e.g., hospital room)             | 50% after deductible                         | Not Covered                                        | <u>Prior authorization</u> may be required or services will not be covered.                                              |
|                                                                                                                                                                                                                    | Physician/surgeon fees                         | 50% after deductible                         | Not Covered                                        | None.                                                                                                                    |

\*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<br>(You will pay the least)                     | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                        |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$50 copayment / office visit; 50% after deductible / outpatient | Not Covered                                        | First three office visits covered at no charge. <u>Prior authorization</u> may be required or services will not be covered.                                            |
|                                                                                  | Inpatient services                        | 50% after deductible                                             | Not Covered                                        | <u>Prior authorization</u> may be required or services will not be covered.                                                                                            |
| <b>If you are pregnant</b>                                                       | Office visits                             | 50% after deductible                                             | Not Covered                                        | Exceptions may apply. *See Family Planning section.                                                                                                                    |
|                                                                                  | Childbirth/delivery professional services | 50% after deductible                                             | Not Covered                                        | None.                                                                                                                                                                  |
|                                                                                  | Childbirth/delivery facility services     | 50% after deductible                                             | Not Covered                                        | <u>Prior authorization</u> 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>                   | 50% after deductible                                             | Not Covered                                        | <u>Prior authorization</u> may be required or services will not be covered.                                                                                            |
|                                                                                  | <u>Rehabilitation services</u>            | \$100 copayment                                                  | Not Covered                                        | Combined 30 visits for physical / occupational therapy and chiropractic services. 30 visits for speech therapy. Visit limits do not apply to mental illness diagnoses. |
|                                                                                  | <u>Habilitation services</u>              | \$100 copayment                                                  | Not Covered                                        | Combined 30 visits for physical / occupational therapy and chiropractic services. 30 visits for speech therapy. Visit limits do not apply to mental illness diagnoses. |
|                                                                                  | <u>Skilled nursing care</u>               | 50% after deductible                                             | Not Covered                                        | Coverage is limited to 60 days. <u>Prior authorization</u> may be required or services will not be covered.                                                            |
|                                                                                  | <u>Durable medical equipment</u>          | 50% after deductible                                             | Not Covered                                        | <u>Prior authorization</u> may be required or services will not be covered. Limits may apply.                                                                          |
|                                                                                  | <u>Hospice services</u>                   | 50% after deductible                                             | Not Covered                                        | <u>Prior authorization</u> may be required or services may 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                        |
| If your child needs dental or eye care | Children's eye exam        | No Charge                                    | Not Covered                                        | Limited to one eye exam.                               |
|                                        | Children's glasses         | 50% no deductible                            | Not Covered                                        | Limited to one pair of glasses or contacts.            |
|                                        | Children's dental check-up | No Charge                                    | Not Covered                                        | Limited to two dental cleanings.                       |

### 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
- Non-emergency care when traveling outside the U.S
- Routine eye care (Adult)
- Routine foot care that is palliative or cosmetic
- 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
- Infertility treatment
- 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 [www.BlueConnectNC.com](http://www.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)

|                                          |                                |
|------------------------------------------|--------------------------------|
| ■ <u>The plan's overall deductible</u>   | \$2,500                        |
| ■ <u>Specialist copayment</u>            | \$100                          |
| ■ <u>Hospital (facility) coinsurance</u> | 50% after copayment deductible |
| ■ <u>Other coinsurance</u>               | 50%                            |

#### 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> |
|---------------------------|-----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,500        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$4,800        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$7,310</b> |

### Managing Joe's Type 2 Diabetes

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

|                                          |                                |
|------------------------------------------|--------------------------------|
| ■ <u>The plan's overall deductible</u>   | \$2,500                        |
| ■ <u>Specialist copayment</u>            | \$100                          |
| ■ <u>Hospital (facility) coinsurance</u> | 50% after copayment deductible |
| ■ <u>Other coinsurance</u>               | 50%                            |

#### 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> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,500        |
| <u>Copayments</u>                 | \$600          |
| <u>Coinsurance</u>                | \$800          |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$3,920</b> |

### Mia's Simple Fracture

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

|                                          |                                |
|------------------------------------------|--------------------------------|
| ■ <u>The plan's overall deductible</u>   | \$2,500                        |
| ■ <u>Specialist copayment</u>            | \$100                          |
| ■ <u>Hospital (facility) coinsurance</u> | 50% after copayment deductible |
| ■ <u>Other coinsurance</u>               | 50%                            |

#### 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> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$2,100        |
| <u>Copayments</u>                 | \$600          |
| <u>Coinsurance</u>                | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,700</b> |

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

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service people with disabilities as well as free language services for people whose primary language is not English. Please contact the Customer Service number on the back of your ID card for assistance.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a las personas con discapacidades, así como servicios lingüísticos gratuitos para las personas cuyo idioma principal no es el inglés. Comuníquese con el número para servicio al cliente que aparece en el reverso de su tarjeta del seguro para obtener ayuda.