



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: \$6,350 Individual/\$6,550 Family Member/\$12,700 Family Total. Out-of-Network: \$12,700 Individual/\$13,100 Family Member/\$25,400 Family Total. | 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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. |
| Are there services covered before you meet your deductible? | Yes. Preventive care. | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | In-Network: \$6,350 Individual/\$6,550 Family Member/\$12,700 Family Total. Out-of-Network: \$13,100 Individual/\$13,100 Family Member/\$28,000 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 <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met. |
| What is not included in the out-of-pocket limit? | <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> . |
| 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 <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-</u> |

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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | <u>Specialist</u> visit | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | <u>Preventive care/screening/immunization</u> | No Charge | 30% <u>coinsurance</u> | -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) | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| If you need drugs to treat your illness or condition | Tier 1 Drugs | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | -Prior authorization may be required or services will not be covered -For Infertility dosage limits apply - *See <u>Prescription Drug</u> section. |
| | Tier 2 Drugs | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | |
| | Tier 3 Drugs | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | |

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|---|--|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| More information about prescription drug coverage is available at www.bluecrossnc.com/rxinfo | Tier 4 Drugs | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | |
| | Tier 5 Drugs | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | None |
| | <u>Emergency medical transportation</u> | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | None |
| | <u>Urgent care</u> | 0% <u>coinsurance</u> | 0% <u>coinsurance</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | -Prior authorization may be required or services will not be covered |
| | Physician/surgeon fees | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | -Prior authorization may be required or services will not be covered |
| | Inpatient services | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | -Prior authorization may be required or services will not be covered |
| | Office visits | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | -*See Family Planning section. |

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| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you are pregnant | Childbirth/delivery professional services | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | None |
| | Childbirth/delivery facility services | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | -Prior authorization may be required or services will not be covered |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | -Prior authorization may be required or services will not be covered |
| | <u>Rehabilitation services</u> | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | -*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). |
| | <u>Habilitation services</u> | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | - <u>Habilitation services</u> are combined with the <u>Rehabilitation service</u> limits listed above. |
| | <u>Skilled nursing care</u> | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | -Coverage is limited to 60 days . - Prior authorization may be required or services will not be covered |
| | <u>Durable medical equipment</u> | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | -Prior authorization may be required or services will not be covered -Limits may apply |
| | <u>Hospice services</u> | 0% <u>coinsurance</u> | 30% <u>coinsurance</u> | -Prior authorization 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) | |
| If your child needs dental or eye care | Children's eye exam | No Charge | 30% <u>coinsurance</u> | -Limits may apply |
| | Children's glasses | Not Covered | 0% <u>coinsurance</u> | 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
- Cosmetic surgery
- 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.
- Hearing aids up to age 22
- 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. 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 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: 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, kwijigo holne' 1-877-275-9787.

To see examples of how this plan might cover costs for a sample medical situation, see the next section

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 de seguro para obtener ayuda.

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