
 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, contact [www.bcbsnc.com](http://www.bcbsnc.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 <https://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 <a href="#">deductible</a> ?	In-Network- \$500 Individual/\$1,250 Family Total. Out-of-Network- \$1,250 Individual/\$3,125 Family Total. Doesn't apply to In-Network <a href="#">preventive care</a> . <a href="#">Coinsurance</a> and <a href="#">copayments</a> do not apply to the <a href="#">deductible</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive services</a> .	For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In-Network- \$2,500 Individual/\$6,250 Family Total. Out-of-Network- \$6,250 Individual/\$15,625 Family Total.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. <i>Note: A separate \$1,000 out-of-pocket (in and out-of-network) applies to Behavioral Health/CBHA services.</i>
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, health care this <a href="#">plan</a> doesn't cover and penalties for failure to obtain <a href="#">pre-authorization</a> for services.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.bcbsnc.com/FindADoctor">www.bcbsnc.com/FindADoctor</a> or call 1-877-275-9787 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's charge</a> and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$25/visit	30% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$40/visit	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. Limits may apply
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	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> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> Retail: 844-265-1875 Mail order: 800-763-0044	Tier 1 - Generic drugs	\$15 Copay Retail \$37.50 Copay Mail	\$20 Copay Retail**	Retail supply = up to 30 days per copay. Mail order supply = up to 90 days per copay.
	Tier 2 - Preferred brand drugs	\$30 Copay Retail \$75 Copay Mail	\$35 Copay Retail**	If you or your physician requests the brand name drug when a generic is available, you will be required to pay the greater of the generic copay plus the cost difference between the brand and generic.
	Tier 3 - Non-preferred brand drugs	\$60 Copay Retail \$150 Copay Mail	\$65 Copay Retail**	Certain drugs require prior authorization, step therapy and/or have limits on quantities that can be dispensed.
	Tier 4 - <a href="#">Specialty drugs</a> - through BriovaRx Specialty Pharmacy. Briovarx.com or 855-427-4682	10% coinsurance with \$50 minimum, \$100 maximum 30 day supply	Not Covered	**Out of network must pay in full and file claim.  **Non-preferred pharmacies will apply a \$5 additional copay. Contact Optum Rx with questions regarding the network status of your pharmacy.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200/visit	\$200/visit	None
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$50/visit	\$50/visit	None

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsnc.com](http://www.bcbsnc.com).

<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> Carolina Behavioral Health Alliance (CBHA): 800-475-7900, or <a href="http://www.cbhallc.com">www.cbhallc.com</a>	Outpatient services	\$25/visit	30% <u>coinsurance</u>	Prior Authorization may be required
	Inpatient services	No Charge	30% <u>coinsurance</u>	Precertification required
<b>If you are pregnant</b>	Office visits	\$25/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>	<a href="#">Home health care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior review and certification of services may be required or services will not be covered
	<a href="#">Rehabilitation services</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	*See Therapies section: 40 visits/ benefit period includes PT/OT. 20 visits/benefit period Speech Therapy
	<a href="#">Habilitation services</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Habilitation services</u> are combined with the <u>Rehabilitation service</u> limits listed above.
	<a href="#">Skilled nursing care</a>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Coverage is limited to 90 days per benefit period. Prior review and certification of services may be required or services will not be covered
	<a href="#">Durable medical equipment</a>	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
	<a href="#">Hospice services</a>	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	\$25/visit	30% <u>coinsurance</u>	Limits may apply
	Children's glasses	Not Covered	Not Covered	Excluded Service
	Children's dental check-up	Not Covered	Not Covered	Excluded Service

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbsnc.com](http://www.bcbsnc.com).

## 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.bcbsnc.com](http://www.bcbsnc.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: BCBSNC at 1-877-258-3334 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'adoowol nínzingo kwojì' 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayments</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$80
Coinsurance	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,700</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayments</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$300
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,400</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayments</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$400
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$900</b>

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-877-275-9787.