

 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. 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 deductible?	In-Network- \$1,000 Individual/\$2,500 Family Total. Out-of-Network- \$2,500 Individual/\$6,250 Family Total. Doesn't apply to In-Network preventive care . Coinsurance and copayments do not apply to the deductible .	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 services .	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- \$4,000 Individual/\$10,000 Family Total. Out-of-Network- \$10,000 Individual/\$25,000 Family Total.	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. <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 out-of-pocket limit?	Premiums , balance-billed 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.bcbsnc.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	\$25/visit	40% coinsurance	None
	Specialist visit	\$40/visit	40% coinsurance	None
	Preventive care/screening/immunization	No Charge	40% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services are preventive . Then check what your plan will pay for. Limits may apply
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior review and certification of services 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 www.optumrx.com 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**	
	Tier 4 - Specialty drugs - through BriovaRx Specialty Pharmacy. Briovarx.com or 855-427-4682	10% coinsurance with \$50 minimum, \$100 maximum 30 day supply	Not Covered	Certain drugs require prior authorization, step therapy and/or have limits on quantities that can be dispensed. **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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	\$200/visit	\$200/visit	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	\$50/visit	\$50/visit	None

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

If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior review and certification of services may be required or services will not be covered
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services Carolina Behavioral Health Alliance (CBHA): 800-475-7900, or www.cbhallc.com	Outpatient services	\$25/visit	40% <u>coinsurance</u>	Prior Authorization may be required
	Inpatient services	No Charge	40% <u>coinsurance</u>	Precertification required
If you are pregnant	Office visits	\$25/visit	40% <u>coinsurance</u>	*See Family planning section. - <u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	No coverage for maternity for dependent children.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior review and certification of services may be required or services will not be covered
	Rehabilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	*See Therapies section: 40 visits/ benefit period includes PT/OT. 20 visits/benefit period Speech Therapy
	Habilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Habilitation services</u> are combined with the <u>Rehabilitation service</u> limits listed above.
	Skilled nursing care	20% <u>coinsurance</u>	40% <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
	Durable medical equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior review and certification of services may be required or services will not be covered. Limits may apply
	Hospice services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required
If your child needs dental or eye care	Children's eye exam	\$25/visit	40% <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

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
- 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. 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 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. 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**

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 [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayments](#) \$40
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$80
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,200

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 copayments](#) \$40
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$300
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,300

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayments](#) \$40
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$700
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100

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.