This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsnc.com/booklets or by calling 1-888-206-4697.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$500** Individual/**$1,000** Family. Out-of-Network: **$1,000** Individual/**$2,000** Family. Doesn't apply to In-Network preventive care. Coinsurance and copayments do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	In-Network: **$800** Individual/**$1,600** Family. Out-of-Network: **$1,600** Individual/**$3,200** Family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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**.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of In-Network providers, visit www.bcbsnc.com/content/providersearch/index.htm or call 1-800-446-8053.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 3 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance amounts**.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copayment/visit	60% after deductible/visit	---none---
	Specialist visit	Tier 1/Tier 2: $20/$35 copayment/visit	60% after deductible/visit	---none---
	Other practitioner office visit	Tier 1/Tier 2: $20/$35 copayment/visit	60% after deductible/visit	Limits may apply.
	Preventive care / screening / immunization	No Charge	Not Covered	Limits may apply.
If you have a test	Diagnostic test (x-ray, blood work)	Tier 1/Tier 2: 30%/50% after deductible	60% after deductible	No coverage for tests not ordered by a doctor.
	Imaging (CT/PET scans, MRIs)	Tier 1/Tier 2: 30%/50% after deductible	60% after deductible	Precertification may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsnc.com/content/services/formulary/presdrugben.htm	Tier 1 Drugs	$4 copayment	$4 copayment	No coverage for drugs in excess of quantity limits, or therapeutically equivalent to an over the counter drug. Other coverage limits may apply.
	Tier 2 Drugs	$10 copayment	$10 copayment	Same as above.
	Tier 3 Drugs	$20 copayment	$20 copayment	Same as above.
	Tier 4 Drugs	$80 copayment	$80 copayment	Same as above.
	Tier 5 Drugs	25%	25%	Same as above.
	Tier 6 Drugs	35%	35%	Same as above.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Tier 1/Tier 2: 30%/50% after deductible	60% after deductible	---none---
	Physician/surgeon fees	Tier 1/Tier 2: 30%/50% after deductible	60% after deductible	---none---
If you need immediate medical attention	Emergency room services	$300 copayment after deductible/visit	$300 copayment after deductible/visit	---none---
	Emergency medical transportation	30% after deductible	30% after deductible	---none---
	Urgent care	$20 copayment/visit	$20 copayment/visit	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	30% after deductible for Tier 1; $500 per admission copay then 50% after deductible for Tier 2	$500 per admission copay then 60% after deductible	Precertification may be required.
	Physician/surgeon fee	Tier 1/Tier 2: 30%/50% after deductible	60% after deductible	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Tier 1/Tier 2: $20/$35 copayment/office visit and 30%/50% after deductible/ outpatient	60% after deductible	Prior authorization may be required.
	Mental/Behavioral health inpatient services	30% after deductible for Tier 1; $500 per admission copay then 50% after deductible for Tier 2	$500 per admission copay then 60% after deductible	Precertification may be required.
	Substance use disorder outpatient services	Tier 1/Tier 2: $20/$35 copayment/office visit and 30%/50% after deductible/ outpatient	60% after deductible	Prior authorization may be required.
	Substance use disorder inpatient services	30% after deductible for Tier 1; $500 per admission copay then 50% after deductible for Tier 2	$500 per admission copay then 60% after deductible	Precertification may be required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	Tier 1/Tier 2: 30%/50% after deductible	60% after deductible	---none---
	Delivery and all inpatient services	30% after deductible for Tier 1; $500 per admission copay then 50% after deductible for Tier 2	$500 per admission copay then 60% after deductible	Precertification may be required
If you need help recovering or have other special health needs	Home health care	30% after deductible	60% after deductible	Prior authorization may be required for benefits to be provided.
	Rehabilitation services	$20 copayment	60% after deductible	Coverage is limited to 30 visits per benefit period for Occupational Therapy / Physical Therapy / Chiropractic services combined and 30 visits per benefit period for Speech Therapy.
	Habilitation services	$20 copayment	60% after deductible	Same as above.
	Skilled nursing care	30% after deductible	60% after deductible	Coverage is limited to 60 days per benefit period. Precertification may be required.
	Durable medical equipment	30% after deductible	60% after deductible	Prior authorization may be required for benefits to be provided. Limits may apply.
	Hospice service	30% after deductible	60% after deductible	Precertification may be required for inpatient services.
If your child needs dental or eye care	Eye exam	$5 copayment	60% after deductible	Limits may apply.
	Glasses	50% no deductible	50% no deductible	Limited to one pair of glasses or contacts per benefit period.
	Dental check-up	No Charge	30% after deductible	Limited to twice per benefit period.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic Surgery and Services
- Dental Care (Adult)
- Routine Eye Care (Adult)
- Long Term Care, Respite Care, Rest Cures
- Routine Foot Care
- Weight Loss Programs
- Abortion (Except in the cases of rape, incest, or when the life of the mother is endangered)

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric Surgery
- Chiropractic Care
- Hearing Aids up to Age 22
- Infertility Treatment
- Non-emergency care when traveling outside the U.S. (For coverage provided outside the U.S., visit www.bcbsnc.com)
- Private Duty Nursing

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact BCBSNC at 1-888-206-4697. You may also contact your state insurance department at 1201 Mail Service Center, Raleigh, NC 27699-1201, or toll free 1-855-408-1212.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: North Carolina 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**. Services provided by Health Insurance Smart NC are available through the North Carolina Department of Insurance. Contact Health Insurance Smart NC, North Carolina Department of Insurance, 1201 Mail Service Center, Raleigh, NC 27699-1201, toll free: 1-855-408-1212.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

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, kwiijigo holne' 1-888-206-4697.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,540
- **Patient pays** $1,000

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$10
Coinsurance	$300
Limits or exclusions	$200
Total	**$1,000**

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,500
- **Patient pays** $900

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$100
Coinsurance	$200
Limits or exclusions	$80
Total	**$900**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

BlueCross BlueShield of North Carolina

Non-Discrimination and Accessibility Notice

Discrimination is Against the Law

- Blue Cross and Blue Shield of North Carolina ("BCBSNC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
- BCBSNC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

  BCBSNC:

  - Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

- If you need these services, contact Customer Service **1-888-206-4697**, TTY and TDD, call **1-800-442-7028**.
- If you believe that BCBSNC 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:

  ➢ BCBSNC, PO Box 2291, Durham, NC 27702, Attention: Civil Rights Coordinator- Privacy, Ethics & Corporate Policy Office, Telephone **919-765-1663**, Fax **919-287-5613**, TTY **1-888-291-1783** civilrightscoordinator@bcbsnc.com

- You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, 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 *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 **1-800-368-1019, 800-537-7697** (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.
- This Notice and/or attachments may have important information about your application or coverage through BCBSNC. 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 Customer Service **1-888-206-4697**.

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).

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

ចំណាំ៖ ប្រសិនបើលោកអ្នកនិយាយជាភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនសម្រាប់លោកអ្នកដោយមិនគិតថ្លៃ។ 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 हिन्दी 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, ໂດຍບໍ່ເສັງຄ່າ, 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。