**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.mychoicehealth.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 1-855-227-5884 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $6,750 Individual $13,500 Family | 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 policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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?** | $6,750 Individual / $6750 Family Member / $13,500 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, the overall out-of-pocket limit must be met. |
| **What is not included in the out-of-pocket limit?** | Charges over the Maximum Allowable Cost, premiums; balance-billing charges; heath 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?** | Not applicable. | This plan does not use a provider network. You can receive covered services from any provider. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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

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 |
|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 0% Coinsurance after Deductible | None |
| | Specialist visit | No Charge after Deductible | None |
| | Preventive care/screening/ immunization | 0% Coinsurance, Deductible does not apply | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Limits may apply. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 0% Coinsurance after Deductible | None |
| | Imaging (CT/PET scans, MRIs) | 0% Coinsurance after Deductible | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at https:///www.citizensrx.com | Generic drugs | 0% Coinsurance after Deductible | Covers up to a 34-day supply for Retail and Specialty; Covers up to a 90-day supply for Mail Order. |
| | Preferred brand drugs | 0% Coinsurance after Deductible | |
| | Non-preferred brand drugs | 0% Coinsurance after Deductible | |
| | Specialty drugs | 0% Coinsurance after Deductible | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 0% Coinsurance after Deductible | None |
| | Physician/surgeon fees | 0% Coinsurance after Deductible | |
| | Emergency room care | 0% Coinsurance after Deductible | None |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| **If you need immediate medical attention** | Emergency medical transportation | 0% Coinsurance after Deductible | None |
| | Urgent care | 0% Coinsurance after Deductible | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% Coinsurance after Deductible | None |
| | Physician/surgeon fees | 0% Coinsurance after Deductible | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 0% Coinsurance after Deductible | None |
| | Inpatient services | 0% Coinsurance after Deductible | None |
| **If you are pregnant** | Office visits | 0% Coinsurance after Deductible | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Coverage is provided for all covered members. |
| | Childbirth/delivery professional services | 0% Coinsurance after Deductible | |
| | Childbirth/delivery facility services | 0% Coinsurance after Deductible | |
| **If you need help recovering or have other special health needs** | Home health care | 0% Coinsurance after Deductible | None |
| | Rehabilitation services | 0% Coinsurance after Deductible | 30 visits / benefit period for physical / occupational therapy and chiropractic services.<br><br>30 visits / benefit period for speech therapy |
| | Habilitation services | 0% Coinsurance after Deductible | 30 visits / benefit period for physical / occupational therapy and chiropractic services.<br><br>30 visits / benefit period for speech therapy |
| | Skilled nursing care | 0% Coinsurance after Deductible | None |
| | Durable medical equipment | 0% Coinsurance after Deductible | None |

| Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|
| | Hospice services | 0% Coinsurance after Deductible | None |
| **If your child needs dental or eye care** | Children's eye exam | 0% Coinsurance after Deductible | One routine eye exam per benefit year. |
| | Children's glasses | 0% Coinsurance after Deductible | One pair of glasses or contact lenses once per benefit year. |
| | Children's dental check-up | No charge | Twice per benefit year. |

## 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)
- Routine Eye Care (Adult)
- Routine Foot Care
- 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 (preauthorization is required)
- Chiropractic Care
- Hearing aids up to age 22
- Infertility Treatment
- Non-emergency care when traveling outside the U.S. Coverage outside of the United States
- 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.ncodi.com/Smart or 1-855-408-1212 or contact Blue Cross NC at 1-855-227-5884. 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: Blue Cross NC at 1-855-227-5884 or mccustomersupport@acsbenefitsservices.com. You may also contact N.C. Department of Insurance at 1201 Mail Service Center, Raleigh, NC 27699-1201 or Toll free (855) 408-1212.

Additionally, a consumer assistance program can help you file your appeal. Contact Health Insurance Smart NC at 1201 Mail Service Center, Raleigh, NC 27699-1201 or toll free 1-855-408-1212,

## 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 1-855-227-5884.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-227-5884.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-855-227-5884.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-227-5884.

*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 pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $6,750 |
| Specialist coinsurance | 0% |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance 0% | 0% |

**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** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $6,800 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$6,900** |

### Managing Joe's type 2 Diabetes
(a year of routine care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $6,750 |
| Specialist coinsurance | 0% |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $6,600 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$6,700** |

### Mia's Simple Fracture
(emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $6,750 |
| Specialist coinsurance | 0% |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,900 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,900** |

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