



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?	\$5,000 Individual \$10,000 Family	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 deductible must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u>	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a copayment or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost sharing 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?	\$5,000 Individual / \$6750 Family Member / \$10,000 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 plan, the <u>overall out-of-pocket limit</u> must be met.
What is not included in the out-of-pocket limit?	Charges over the Maximum Allowable Cost, <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 out-of-pocket limit.
Will you pay less if you use a network provider?	Not applicable.	This <u>plan</u> does not use a <u>provider network</u> . You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

*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 <u>Deductible</u>	None
	<u>Specialist</u> visit	No Charge after <u>Deductible</u>	None
	<u>Preventive care/screening/immunization</u>	0% Coinsurance, <u>Deductible</u> does not apply	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% Coinsurance after <u>Deductible</u>	None
	Imaging (CT/PET scans, MRIs)	0% Coinsurance after <u>Deductible</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.citizensrx.com	Generic drugs	0% Coinsurance after <u>Deductible</u>	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 <u>Deductible</u>	
	Non-preferred brand drugs	0% Coinsurance after <u>Deductible</u>	
	<u>Specialty drugs</u>	0% Coinsurance after <u>Deductible</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% Coinsurance after <u>Deductible</u>	None
	Physician/surgeon fees	0% Coinsurance after <u>Deductible</u>	
	<u>Emergency room care</u>	0% Coinsurance after <u>Deductible</u>	None

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency medical transportation</u>	0% Coinsurance after <u>Deductible</u>	None
	<u>Urgent care</u>	0% Coinsurance after <u>Deductible</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% Coinsurance after <u>Deductible</u>	None
	Physician/surgeon fees	0% Coinsurance after <u>Deductible</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% Coinsurance after <u>Deductible</u>	None
	Inpatient services	0% Coinsurance after <u>Deductible</u>	None
If you are pregnant	Office visits	0% Coinsurance after <u>Deductible</u>	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 <u>Deductible</u>	
	Childbirth/delivery facility services	0% Coinsurance after <u>Deductible</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% Coinsurance after <u>Deductible</u>	None
	<u>Rehabilitation services</u>	0% Coinsurance after <u>Deductible</u>	30 visits / benefit period for physical / occupational therapy and chiropractic services. 30 visits / benefit period for speech therapy
	<u>Habilitation services</u>	0% Coinsurance after <u>Deductible</u>	30 visits / benefit period for physical / occupational therapy and chiropractic services. 30 visits / benefit period for speech therapy
	<u>Skilled nursing care</u>	0% Coinsurance after <u>Deductible</u>	None
	<u>Durable medical equipment</u>	0% Coinsurance after <u>Deductible</u>	None

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

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

* For more information about limitations and exceptions, see plan or policy document at www.mychoicehealth.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
- Cosmetic Surgery
- Routine Foot Care
- Dental Care (Adult)
- Weight Loss Programs
- Routine Eye Care (Adult)

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)
- Infertility Treatment
- Private duty nursing
- Chiropractic Care
- Non-emergency care when traveling outside the U.S. Coverage outside of the United States
- Hearing aids up to age 22

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@acsbenefitservices.com. You may also receive assistance from the Department of Labor's Employee Benefits Security Administration at 1-988-444-EBSA (3272) or www.dolgov/ebsa/healthreform if applicable. 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, kwijigo 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** \$5,000
- **Specialist coinsurance** 0%

- **Hospital (facility) coinsurance** 0%

- **Other coinsurance** 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$5,100
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Managing Joe's type 2 Diabetes
(a year of routine care of a well-controlled condition)

- **The plan's overall deductible** \$5,000
- **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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$55
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The total Joe would pay is	\$5,100
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Mia's Simple Fracture
(emergency room visit and follow up care)

- **The plan's overall deductible** \$5,000
- **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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$1,900
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The plan would be responsible for the other costs of these EXAMPLE covered services