Blue Cross and Blue Shield of North Carolina: Blue Local Silver 3500 with Carolinas HealthCare System

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | **Plan Type:** POS

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 1-877-258-3334.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network **$3,500** Individual / **$7,000** Family. Out-of-Network **$7,000** Individual / **$14,000** 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?	Yes. $200 for prescription drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network **$6,850** Individual / **$13,700** Family. Out-of-Network **$13,700** Individual / **$27,400** 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.

Questions: Call 1-877-258-3334 or visit us at www.bcbsnc.com/booklets.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov/programs/consumer/summaryandglossary/index.html or call 1-877-258-3334 to request a copy.

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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, see 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 7. 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	$25 copayment/ visit	60% after deductible/ visit	---none---
	Specialist visit	$50 copayment/ visit	60% after deductible/ visit	---none---
	Other practitioner office visit	$50 copayment/ Chiropractic visit	60% after deductible/ Chiropractic 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)	30% after deductible	60% after deductible	No coverage for tests not ordered by a doctor.
	Imaging (CT/PET scans, MRIs)	30% after deductible	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 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	$10 copayment after prescription drug deductible	$10 copayment after prescription drug deductible	No coverage for drugs in excess of quantity limits, or therapeutically equivalent to an over the counter drug. For Infertility, dosage limits apply.
	Tier 2 Drugs	$25 copayment after prescription drug deductible	$25 copayment after prescription drug deductible	Same as above.
	Tier 3 Drugs	$50 copayment after prescription drug deductible	$50 copayment after prescription drug deductible	Same as above.
	Tier 4 Drugs	$70 copayment after prescription drug deductible	$70 copayment after prescription drug deductible	Same as above.
	Tier 5 Drugs	25% after prescription drug deductible	25% after prescription drug deductible	Coverage is limited to a 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% after deductible	60% after deductible	---none---
	Physician/surgeon fees	30% after deductible	60% after deductible	---none---

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 need immediate medical attention	Emergency room services	$500 copayment/ visit	$500 copayment/ visit	---none---
	Emergency medical transportation	30% after deductible	30% after deductible	---none---
	Urgent care	$50 copayment/ visit	$50 copayment/ visit	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	30% after deductible	60% after deductible	Precertification may be required.
	Physician/surgeon fee	30% after deductible	60% after deductible	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$50 copayment/ office visit and 30% after deductible/ outpatient	60% after deductible	Precertification may be required.
	Mental/Behavioral health inpatient services	30% after deductible	60% after deductible	Precertification may be required.
	Substance use disorder outpatient services	$50 copayment/ office visit and 30% after deductible/ outpatient	60% after deductible	Precertification may be required.
	Substance use disorder inpatient services	30% after deductible	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	30% after deductible	60% after deductible	---none---
	Delivery and all inpatient services	30% after deductible	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	$50 copayment	60% after deductible	Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for Occupational Therapy/Physical Therapy/Chiropractic and 30 visits per benefit period for Speech Therapy.
	Habilitation services	$50 copayment	60% after deductible	Coverage is limited to 30 visits per benefit period for Rehabilitation and Habilitation services combined, for Occupational Therapy/Physical Therapy/Chiropractic and 30 visits per benefit period for Speech Therapy.
	Skilled nursing care	30% after deductible	60% after deductible	Coverage is limited to 60 days per benefit period. Precertification 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 required for inpatient services.

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 your child needs dental or eye care	Eye exam	$25 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 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.

  Coverage provided outside the United States. See 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 1-800-446-8053. You may also contact your state insurance department at 1201 Mail Service Center, Raleigh, NC 27699-1201, or toll free 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 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: (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 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'adoowoł nínzingo kwojį' hólne', naaltsoos áłts'ísí nantinígíí bine'dęę' binámboo bikáá'.

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 $2,840**
- **Patient pays $4,700**

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	$3,500
Copays	$40
Coinsurance	$1,000
Limits or exclusions	$200
Total	**$4,700**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,900
- **Patient pays $2,500**

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	$1,800
Copays	$600
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,500**

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.

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