Blue Options℠ Benefit Highlights (PPO)

The coinsurance amounts that appear on this benefit highlight represent Plan responsibility. The coinsurance amounts that display in the benefit booklet represent member responsibility.

Deductibles, Out-of-Pocket Limits & Benefit Maximums *The following Deductibles, Out-of-Pocket Limits, and Benefit Maximums apply to all services. All copays are before deductible.*	**In-network**	**Out-of-network**[1]
Embedded Deductibles		
Individual (per Benefit Period)	$5,000	$10,000
Family (per Benefit Period)	$10,000	$20,000
Embedded Out-of-Pocket Limits		
Individual (per Benefit Period)	$7,150	$14,300
Family (per Benefit Period)	$14,300	$28,600
Benefit Maximums:		
Lifetime Total Dollar Maximum	Unlimited	Unlimited
Lifetime Infertility Benefit Maximum		
Ovulation Induction Cycles *(with insemination, per Member, in all places of service)*	3 Cycle Limits	
Annual Benefit Maximums: *Maximums apply to Home, Office and Outpatient Settings only, unless otherwise indicated. Maximums include both Habilitative and Rehabilitative services unless otherwise indicated. All maximums are on a combined In- and Out-of-Network basis per Member, per Benefit Period.*		
Physical, Occupational and Chiropractic Therapies (combined)	30 visits	
Speech Therapy	30 visits	
Applied Behavioral Analysis (ABA) Therapy (ages 18 and younger)	$40,000	
Skilled Nursing Facility Stay	60 days	
Provider Office visits for the evaluation and treatment of obesity (maximum does not apply to dietician/nutritional visits)	4	
Physician Office Services *(See "Outpatient Services" for "outpatient clinic" or "hospital-based" services.)*		
Office Visit *Includes all Office Visits regardless of specialty or diagnosis (including medical, mental health, substance abuse, telehealth, infertility, therapies and pre-natal/post -delivery care unable to be included in the global delivery fee). Includes Office Surgery, Consultation, X-rays and Labs.*		
Primary Care Provider	$35	30% after deductible
Specialist	$70	30% after deductible
Vendor Telehealth *Includes Telehealth services for medical/acute care*	$35	Benefits not available
Preventive Care (Primary Preventive Diagnosis Only) *For the most updated list of general preventive/screenings, immunizations, well-baby/well-child care, womens preventive care services, nutritional counseling and other services mandated under Federal law, see our website at bcbsnc.com/preventive.*		
Primary Care Provider	100% no deductible	70% after deductible*
Specialist	100% no deductible	70% after deductible*
**Only state mandated services including, but not limited to, colorectal screening, bone mass measurement, newborn hearing screening, prostate specific antigen tests (PSAs), gynecological exams, cervical cancer screening, ovarian cancer screening and screening mammograms are covered Out-of-Network.*		

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Urgent and Emergency Care	In-network	Out-of-network[1]
Urgent Care Centers	$75	$75
Emergency Room Visit*	$500	$500
Ambulance	60% after deductible	60% after deductible

**If admitted from the ER, any applicable ER member responsibility does not apply; instead, Inpatient Hospital benefits apply. If held for observation, Outpatient benefits apply. See "Inpatient Hospital Services" and "Outpatient Services". Out-of-Network Emergency Room services are payable at the In-Network level and applied to the In-Network Out- of-Pocket Limit regardless of where they are obtained.*

Inpatient Hospital Services		
Includes all Inpatient Hospital Services regardless of diagnosis (including, but not limited to, medical, mental health, substance abuse, infertility, therapies, transplants, deliveries, and surgeries.)		
Inpatient Hospital Facility Services	60% after deductible	30% after deductible
Inpatient Hospital Professional Services	60% after deductible	30% after deductible

Outpatient Services		
Hospital Based or Free-standing Facility Services *(other than preventive services above)*	60% after deductible	30% after deductible
Outpatient Diagnostic Services		
Outpatient lab tests when performed alone *(Professional and Facility Services)*	100% no deductible	70% after deductible
Outpatient lab tests when performed with another service		
Professional Services	100% no deductible	70% after deductible
Facility Services	60% after deductible	30% after deductible
Outpatient Mammography	100% no deductible	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEGs and EKGs	60% after deductible	30% after deductible
Other Services		
Skilled Nursing Facility	60% after deductible	30% after deductible
Home Health Care and Hospice	60% after deductible	30% after deductible
Durable Medical Equipment, Prosthetics and Orthotics	60% after deductible	30% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including a physician's office	60% after deductible	30% after deductible

Blue Options[SM] Benefit Highlights (PPO)

Prescription Drugs	In-network	Out-of-network[1]
Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bcbsnc.com/preventive	100% no deductible	100% no deductible

Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments.
Prescription Drug copayments, coinsurance* and deductibles* (*if applicable) apply to the Out-of-Pocket limit.*
MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed).
Penalty does not count toward OOP Limit. Essential 5 Tier Commercial, Limited NC Network Formulary.
Prior Plan approval, step therapy and quantity limits may apply.

Tier 1 Drugs	$10	$10
Tier 2 Drugs	25%	25%
Tier 3 Drugs	25%	25%
Tier 4 Drugs	25%	25%
Tier 5 Drugs	25%	25%

There is a $100 per Prescription Maximum for each 30-day supply of Tiers 2 and 3 drugs, and there is a $250 per Prescription Maximum for each 30-day supply of Tiers 4 and 5 drugs.
Any Out-of-Network charges over the allowed amount are not included in this maximum.
You are responsible for charges over the allowed amount received from an Out-of-Network pharmacy.
Limits apply to Infertility drugs, refer to your benefit booklet.

1 NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or co-payment amount because actual provider charges may not be used to determine the payment obligations for Blue Cross NC and its members.

ADDITIONAL INFORMATION ABOUT BLUE OPTIONS℠ FROM BLUE CROSS NC

Benefit Period
The period of time, usually 12 months as stated in the group contract, during which charges for covered services provided to a member must be incurred in order to be eligible for payment by Blue Cross NC. A charge shall be considered incurred on the date the service or supply was provided to a member.

Allowed Amount
The maximum amount that Blue Cross NC determines is to be paid for covered services provided to a member.

Out-of-Pocket Limit
The dollar amount you pay for covered services in a benefit period before Blue Cross NC pays 100% of covered services. It includes deductible, coinsurance and copayments. It does not include charges over the allowed amount, premiums, and charges for non-covered services.

Utilization Management
To make sure you have access to high quality, cost-effective health care, we manage utilization through a variety of programs including certification, transplant management, concurrent and retrospective review. If you have a concern regarding the final determination of your care, you have the right to appeal the decision. For further information about our Utilization Management programs, please refer to your benefit booklet.

Certification
Certification is a program designed to make sure that your care is given in a cost effective setting and efficient manner.
If you need to be hospitalized, you must obtain certification. Non-emergency and non-maternity hospital admissions must be certified prior to the hospitalization. If the admission is not certified, the claim will be denied.
For maternity admissions, your provider is not required to obtain certification from Blue Cross NC for prescribing a length of stay up to 48 hours for a normal vaginal delivery, or up to 96 hours for delivery by cesarean section. You or your provider must request certification for coverage for additional days, which will be given by Blue Cross NC, if medically necessary.
All inpatient and certain outpatient Mental Health and Substance Abuse services and all Adaptive Behavior Treatment must be certified in advance by Magellan Behavioral Health. Call Magellan Behavioral Health at 1-800-359-2422. Mental Health and Substance Abuse office visits do not require certification.
In-network providers in North Carolina are responsible for obtaining certifications. The member will bear no financial penalties if the in-network provider in North Carolina fails to obtain the appropriate authorization. The member is responsible for obtaining certification for services rendered by an out-of-network provider in North Carolina or by any provider outside of North Carolina.

Health and Wellness Program
Because we want to help you stay healthy, we offer a variety of wellness benefits and services. You can take advantage of the Health Line Blue℠, our 24-hour free nurse support line, a health topics library, chronic condition management and a prenatal program. You will also have access to online health and wellness tools and trackers at BlueConnectNC.com. With our program you can get health advice anytime you need it, so you can learn how to take charge of your health.

What is Not Covered?
The following are summaries of some of the coverage restrictions. A full explanation and listing of restrictions will be found in your benefit booklet.

Your health benefit plan does not cover services, supplies, drugs or charges that are:

- Not medically necessary
- For injury or illness resulting from an act of war
- For personal hygiene and convenience items
- For inpatient admissions that are primarily for diagnostic studies
- For palliative or cosmetic foot care
- For investigative or experimental purposes
- For hearing aids or tinnitus maskers, except as specifically covered by the benefit plan
- For cosmetic services or cosmetic surgery
- For custodial care, domiciliary care or rest cures
- For treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- For reversal of sterilization
- For treatment of sexual dysfunction not related to organic disease
- For assisted reproductive technologies as defined by the Centers for Disease Control and Prevention
- For self-injectable drugs in the provider's office

Embedded Deductible Definition
Members must meet their individual deductible before benefits are payable under the health benefit plan. However, once the family deductible is met, all covered family members will be in benefit. Any member who meets their individual Out-Of-Pocket Limit will have the benefit levels apply to them only and not the entire family. However, once the family Out-Of-Pocket Limit is met, the benefit levels will apply to the entire family.

Plan codes: PB89726 R046310 MP00390 SP00390 C003400 V000100 D000100
Facets codes: MED-FS000601 DRU-BR002205
Billing arrangement: ee, ee+spouse, ee+children, fam