BlueCross BlueShield of North Carolina

SEAC of the Carolinas, LLC.

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Blue Options

Prepared By

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The benefit highlight is a summary of Blue Options benefits. This is meant only to be a summary. You will also be receiving a Summary of Benefits and Coverage document (referred to as an SBC) required under Health Care Reform. Both documents are provided as a convenience to compare available health plan coverage options. Final interpretation of the Blue Options health plan and a complete listing of benefits and what is not covered are found in and governed by the group contract and benefit booklet. You may preview the benefit booklet by requesting a copy of the Blue Options benefit booklet from Blue Cross and Blue Shield of North Carolina (BlueCross NC) Customer Service.

Blue Options Benefit Highlights (PPO)

The amounts that appear on this benefit highlight represent member responsibility.

Deductibles, Out-of-Pocket Limits & Benefit Maximums	**In-network**	**Out-of-network** [1]
The following Deductibles and Out-of-Pocket Limits apply to all services unless unless otherwise indicated.		
Embedded Deductibles		
Individual (per Benefit Period)	$6,000	$12,000
Family (per Benefit Period)	$12,000	$24,000
Out-of-Pocket Limits		
Individual (per Benefit Period)	$8,850	$17,700
Family (per Benefit Period)	$17,700	$35,400
Benefit Maximums:		
Lifetime Benefit Maximum	Unlimited	
Lifetime Infertility Benefit Maximum		
Combined In-Network and Out-of-Network Lifetime Maximum of 3 ovulation induction cycles, with or without insemination		
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. There are no limits on therapy and nutritional counseling visits related to mental illness diagnoses.		
Physical, Occupational and Chiropractic Therapies (combined) (Rehabilitative/Habilitative)	30 visits/30 visits	
Speech Therapy (Rehabilitative/Habilitative)	30 visits/30 visits	
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 visits	
Nutritional Counseling	30 visits	
Physician Office Services		
Office Visit		
Includes all Office Visits regardless of specialty or diagnosis (including medical, therapies and pre-natal/post-delivery care unable to be included in the global delivery fee). Includes Office Surgery, Consultation, X-rays (other than sinus surgery. See "Inpatient and Outpatient Services")		
Primary Care Provider (PCP)	$70	70% after deductible
Log in to Blue Connect to select your Primary Care Provider (PCP). Your Copay is waived for your first 3 visits to your selected PCP.		
Specialist	$140	70% after deductible
Vendor Telehealth	No Charge	Benefits not available
Includes Telehealth services for Primary Care, Acute Care, Mental Health Teletherapy, Dermatology and Nutritional Counseling.		
Preventive Care (Primary Preventive Diagnosis Only)		
For the most updated list of general preventive/screenings, immunizations, well-baby/well-child care, women's preventive care services, nutritional counseling and other services mandated under Federal law, see our website at bluecrossnc.com/preventive. *State mandated services include colorectal screening, bone mass measurement, newborn hearing screening, prostate specific antigen tests (PSAs), gynecological exams, cervical cancer screening, ovarian cancer screening and screening mammograms.*		
Primary Care Provider	0% no deductible	30% after deductible
Specialist	0% no deductible	30% after deductible
Therapies		
Adaptive Behavior Treatment is covered, with no annual benefit maximum.		
Primary Care	$70	70% after deductible
Specialist	$140	70% after deductible
Inpatient/Outpatient	40% after deductible	70% after deductible

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Urgent and Emergency Care	**In-network**	**Out-of-network** [1]
Ambulance Services	40% after deductible	40% after deductible
Emergency Room Visit* (with or without Observation)	$2,000	$2,000
Emergency Room Visit (with Inpatient Admission)	40% after deductible	40% after deductible
Urgent Care Services	$140	$280

*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 use disorder, infertility, therapies, transplants, deliveries, and surgeries.)
If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. You may reduce your coinsurance by 10% simply by utilizing an inpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.

Inpatient Hospital Facility Services	40% after deductible	70% after deductible
Inpatient Hospital Professional Services	40% after deductible	70% after deductible

Outpatient services

If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. You may reduce your coinsurance by 10% simply by utilizing an outpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.

Hospital Based Clinics, or Free-Standing Facility Services (other than preventive services above)	40% after deductible	70% after deductible
Outpatient Lab Test	40% after deductible	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEGs and EKGs	40% after deductible	70% after deductible
Sinus surgeries in any location, including a physician's office	40% after deductible	70% after deductible
Diagnostic Outpatient Mammography	0% no deductible	30% after deductible

Other Services

Skilled Nursing Facility	40% after deductible	70% after deductible
Home Health Care, Durable Medical Equipment and Hospice	40% after deductible	70% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including a physician’s office	40% after deductible	70% after deductible

Mental Health and Substance Use Disorder Services	**In-network**	**Out-of-network** [1]
Office Visit	$70	70% after deductible
Inpatient/Outpatient	40% after deductible	70% after deductible

Blue Options Benefit Highlights (PPO)

Prescription Drugs

Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bluecrossnc.com/preventive	0% no deductible	0% no deductible

Prescription Drug copayments*, coinsurance* and deductibles* (*if applicable) apply to the Out-of-Pocket limit.
Up to a 30-day supply is one copayment. A 31-60-day supply is two copayments. A 61-90-day supply is three copayments.
Essential QHP Formulary, Broad Network, MAC B Pricing, Brand Penalty. Prior plan approval, step therapy and quantity limits may apply.

	In-network	
Tier 1 Drugs	$15	$15
Tier 2 Drugs	$35	$35
Tier 3 Drugs	$45	$45
Tier 4 Drugs	$90	$90
Tier 5 Drugs	25%	25%

Diabetic Supplies obtained at the pharmacy will apply to a drug tier. Check your benefit booklet for additional details.
For each 30-day supply of a Tier 5 Drug, you will pay a minimum of $90 in coinsurance, but not more than $200.
Any Out-of-Network charges over the allowed amount are not included in this maximum.

There is a $200 separate pharmacy deductible that must be met before pharmacy benefits are paid.
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.

Pediatric Dental Services*

Preventive Services	No Charge	30% after deductible
Basic and Major	40% after deductible	70% after deductible
Orthodontic Services (if Medically Necessary)	40% after deductible	70% after deductible

*Pediatric Dental is only available for members up through the end of the month they become age 19.

Pediatric Vision Benefits**

Routine Vision Exams	No Charge	30% after deductible
Frames and Lenses or Contact Lenses	50% no deductible	50% after deductible

**Pediatric Vision is only available for members up through the end of the month they become age 19.
For more information, 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

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, charges for non-covered services, Dental and Adult Lens and Frame Coverage. Charges for in-network services only apply to the in-network out-of-pocket limit and charges for out-of-network services only apply to the out-of-network out-of-pocket limit.

Day and Visit Maximums
All day and visit maximums are on a combined In- and Out-of Network basis.

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. If you would like a copy of a benefit booklet providing more information about our Utilization Management programs, call the toll free number listed in your information packet.

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 Use Disorder services and all Adaptive Behavior Treatment must be certified in advance by Blue Cross NC or services will not be covered. Call Blue Cross NC at 1-800-359-2422. Mental Health and Substance Use Disorder 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 or out- of-state provider.

Health and Wellness Program
Your benefits provide access to a variety of wellness programs and services to help you stay healthy. These include nurse support for chronic conditions, pregnancy and behavioral health, as well as tobacco cessation programs and exclusive member discounts on things like gym memberships, glasses, hearing aids and more. You can also access a wide selection of online and digital health and wellness tools and resources at bluecrossnc.com to help you 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 assisted reproductive technologies as defined by the Centers for Disease Control and Prevention
- For self-injectable drugs in the provider's office
- Weight Loss Drugs
- Adult routine Vision exams

MAC B
When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND-NAME PRESCRIPTION DRUG, your cost may be higher.

Please note: You may pay a different amount in certain situations when choosing between GENERIC and BRAND-NAME PRESCRIPTION DRUGS. If you decide you want the BRAND-NAME drug on the higher tier instead of the GENERIC equivalent on the lower tier, you will pay the BRAND-NAME copayment or coinsurance plus the cost difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT. For PRESCRIPTION DRUGS received from an OUT-OF-NETWORK pharmacy, you will also pay any charges over the ALLOWED AMOUNT.

You may not be required to pay the difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT for certain BRAND-NAME PRESCRIPTION DRUGS, if these criteria are met: 1) the BRAND-NAME PRESCRIPTION DRUG is on the Narrow Therapeutic Index (NTI). See [ncbop.org/faqs/Pharmacist/faq_NTIDrugs.htm] for a current list of these drugs; or 2) your PROVIDERS has required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts may still apply.

From time to time, MEMBERS may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce PRESCRIPTION DRUG costs.

Embedded Deductible
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.