Blue High Performance Network Benefit Highlights (EPO)

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

Deductibles, Out-of-Pocket Limits & Benefit Maximums	In-network
The following Deductibles, Out-of-Pocket Limits, and Benefit Maximums apply to all services. All copays are before deductible, if applicable.	
Embedded Deductibles	
Individual (per Benefit Period)	$1,500
Family (per Benefit Period)	$3,000
Embedded Out-of-Pocket Limits	
Individual (per Benefit Period)	$5,750
Family (per Benefit Period)	$11,500
Benefit Maximums:	
Lifetime Total Dollar Maximum	Unlimited
Lifetime Infertility Benefit Maximum	
Ovulation Induction Cycles	3 Cycle Limits
(with or without insemination, per Member, in all places of service)	
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 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)	30 visits
Speech Therapy	30 visits
Adaptive Behavior Treatment	Unlimited
Skilled Nursing Facility Stay	60 days
Provider Office visits for the evaluation and treatment of obesity	4 visits
(maximum does not apply to dietician/nutritional visits)	
Nutritional Counseling Visits	30 visits
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 use disorder, infertility, therapies and pre-natal/post-delivery care unable to be included in the global delivery fee). Includes Office Surgery, Consultation, and X-rays, unless otherwise specified.(See Inpatient and Outpatient Services for additional information on Sinus Surgery benefits).	
Primary Care Provider	$35
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	$70
Mental Health and Substance Use Disorder	$10
Vendor Telehealth	$10
Includes Telehealth services for medical/acute care/behavioral health	
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
Specialist	0% no deductible

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Urgent and Emergency Care	In-network
Ambulance	30% after deductible
Emergency Room Visit*	$500
Urgent Care Centers Services**	$70

**If admitted to the hospital for inpatient or observation services your ER benefit will continue to apply until you are considered stable. 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.*

***You pay $70 when visiting any urgent care provider outside of the HPN product area.*

Inpatient Hospital Services	
Includes all Inpatient Hospital Services regardless of diagnosis (including, but not limited to, medical, mental health, substance use disorder, therapies, transplants, deliveries, and surgeries.) You may receive a better benefit if you receive care at a Blue Distinction Center (BDC). Visit bluecrossnc.com/bdc to find a BDC.	
Inpatient Hospital Facility Services	30% after deductible
Inpatient Hospital Professional Services	30% after deductible
Outpatient Services	
Hospital Based or Free-standing Facility Services *(other than preventive services above)*	30% after deductible
Outpatient Diagnostic Services	
Outpatient lab tests	30% after deductible
Outpatient Mammography	0% no deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEGs and EKGs	30% after deductible
Other Services	
Skilled Nursing Facility	30% after deductible
Home Health Care and Hospice	30% after deductible
Durable Medical Equipment, Prosthetics and Orthotics	30% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including	30% after deductible

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Prescription Drugs	**In-network**
Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bluecrossnc.com/preventive	0% no deductible

Prescription Drug copayments, coinsurance* and deductibles* (*if applicable) apply to the Out-of-Pocket limit.*

Essential QHP, Limited NC Formulary, Network. MAC A Pricing (Brand Penalty when Generic Equivalent is available). Penalty does not count toward OOP Limit. Prior Plan approval, step therapy and quantity limits may apply.

Tier 1 Drugs	$4
Tier 2 Drugs	$15
Tier 3 Drugs	$35
Tier 4 Drugs	$50
Tier 5 Drugs	25%
Tier 6 Drugs	50%

Up to 30-day supply is one copayment. 31-60-day supply is two copayments, and 61-90-day supply is three copayments.

For each 30-day supply of a Tier 5 Drug, you will pay a minimum of $50 in coinsurance, but not more than $100.

For Tier 6 Drug you will pay a minimum of $50 in coinsurance, but not more than $200.

Limits apply to Infertility drugs, refer to your benefit booklet.

Pediatric Dental Services*	
Preventive Services	30% after deductible
Basic and Major	30% after deductible
Orthodontic Services (if Medically Necessary)	30% 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
Frames and Lenses or Contact Lenses	50% after deductible

*Deductible does not apply.
**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.