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 otherwise indicated.		
Embedded Deductibles		
Individual (per Benefit Period)	$1,500	$3,000
Family (per Benefit Period)	$3,000	$6,000
Out-of-Pocket Limits		
Individual (per Benefit Period)	$5,750	$11,500
Family (per Benefit Period)	$11,500	$23,000
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. 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	
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)	$35	60% 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	$70	60% after deductible
Vendor Telehealth	$10	Benefits not available
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	30% after deductible
Specialist	0% no deductible	30% after deductible
Therapies		
Adaptive Behavior Treatment is covered, with no annual benefit maximum.		
Primary Care	$35	60% after deductible
Specialist	$70	60% after deductible
Inpatient/Outpatient	30% after deductible	60% after deductible

Blue Options Benefit Highlights (PPO)

Urgent and Emergency Care	**In-network**	**Out-of-network** [1]
Ambulance	30% after deductible	30% after deductible
Emergency Room Visit*	$500	$500
Urgent Care Centers	$70	$140

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

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.)

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	60% after deductible
Inpatient Hospital Professional Services	30% after deductible	60% after deductible
Outpatient services		
Hospital Based Clinics, or Free-Standing Facility Services (other than preventive services above)	30% after deductible	60% after deductible
Outpatient Lab Test	30% after deductible	60% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEGs and EKGs	30% after deductible	60% after deductible
Sinus surgeries in any location, including physician's office	30% after deductible	60% after deductible
Diagnostic Outpatient Mammography	0% no deductible	30% after deductible
Other Services		
Skilled Nursing Facility	30% after deductible	60% after deductible
Home Health Care, Durable Medical Equipment and Hospice	30% after deductible	60% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including physician’s office	30% after deductible	60% after deductible

Blue Options Benefit Highlights (PPO)

Mental Health and Substance Use Disorder Services	In-network	Out-of-network [1]
Office Visit	$35	60% after deductible
Inpatient/Outpatient	30% after deductible	60% after deductible

Prescription Drugs

Pharmacy benefit includes copayments, co-insurance, and pharmacy deductible (if applicable)
Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments.
Essential QHP Formulary, Broad Network, MAC B Pricing, Brand Penalty Pricing. Prior plan approval, step therapy and quantity limits may apply.

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

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. 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.

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

Pediatric Dental Services*

Preventive Services	No Charge	30% after deductible
Basic and Major	30% after deductible	60% after deductible
Orthodontic Services (if Medically Necessary)	30% after deductible	60% 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%	50%

*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.

[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.