BCBS of North Carolina offers the same plan book to fully insured and self funded plans. L1338

In the fully insured plans and their price quotes, nutritional counseling visits do not apply to mental illness.

In the self funded plans, nutritional counseling visits do apply to mental illness.

If a TPA offers a standard booklet for its fully insured plans and self funded plans then they have an obligation to notify the plan administrator if a limitation is possibly a MHPAEA violation.

Employers should disclose their SPD template number. This will allow for easy identification across all self funded plans of potential violations due to the TPA provided document. Space for this disclosuret should be included in the new version of Form 5500.

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

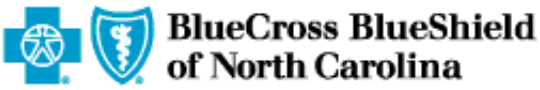
*Pediatric Dental is only available for members up through the end of the month they become age 19.

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.



Western Piedmont Council of Governments

Effective July 1, 2023

Blue Options with HSA Fund
ASO

Prepared By

MARK BROWDER

Prospect # 402205
Quote # 6068753

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 (Blue Cross NC) Customer Service.

The plan is intended to be a high deductible health plan (HDHP) that qualifies its members to contribute to a health savings account (HSA), unless its members are otherwise ineligible under applicable federal requirements. Please consult a qualified tax advisor if you are unsure about whether or not you are ineligible. In addition, the DEDUCTIBLE and OUT-OF-POCKET LIMIT amounts listed in the Summary of Benefits may be revised each year in accordance with Internal Revenue Service (IRS) rulings.

Blue Options with HSA Fund 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, Out-of-Pocket Limits, and Benefit Maximums apply to all services. All copays are before deductible, if applicable.		
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)	$5,000	$10,000
Family (per Benefit Period)	$10,000	$20,000
Benefit Maximums:		
Lifetime Total Dollar Maximum	Unlimited	Unlimited
Lifetime Infertility Benefit Maximum		
Ovulation Induction Cycles *(with or without 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. 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 (maximum does not apply to dietician/nutritional visits)	4 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, Labs, and X-rays, unless otherwise specified.		
Primary Care Provider	0% after deductible	30% after deductible
Specialist	0% after deductible	30% after deductible
Mental Health and Substance Use Disorder	0% after deductible	30% after deductible
Vendor Telehealth	0% after deductible	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

Blue Options with HSA Fund Benefit Highlights (PPO)

Urgent and Emergency Care	**In-network**	**Out-of-network** [1]
Ambulance	0% after deductible	0% after deductible
Emergency Room Visit*	0% after deductible	0% after deductible
Urgent Care Centers Services	0% after deductible	30% after deductible
**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.*		
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	0% after deductible	30% after deductible
Inpatient Hospital Professional Services	0% after deductible	30% after deductible
Outpatient Services		
Hospital Based or Free-standing Facility Services *(other than preventive services above)*	0% after deductible	30% after deductible
Outpatient lab tests	0% after deductible	30% after deductible
Preventive Mammography	0% no deductible	30% after deductible
Diagnostic Mammography	0% after deductible	30% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEGs and EKGs	0% after deductible	30% after deductible
Other Services		
Skilled Nursing Facility	0% after deductible	30% after deductible
Home Health Care and Hospice	0% after deductible	30% after deductible
Durable Medical Equipment, Prosthetics and Orthotics	0% after deductible	30% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including	0% after deductible	30% after deductible

Blue Options with HSA Fund Benefit Highlights (PPO)

Prescription Drugs	**In-network**	**Out-of-network** [1]
Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bluecrossnc.com/preventive	0% no deductible	0% no deductible

All pharmacy coinsurance amounts below apply after the medical deductible is satisfied, and apply to the medical Out-of-Pocket limit.
MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed).
NetResults 5 Tier Commercial, Broad Plus Network Formulary.
Prior Plan approval, step therapy and quantity limits may apply.

Prescription drugs	0% after deductible
Enhanced Preventive Drugs	0% no deductible

Any drugs from the Enhanced Preventive Drug List prescribed for a preventive purpose is covered at 0% no deductible.
You are responsible for charges over the allowed amount received from an Out-of-Network pharmacy, and those amounts are not included in the Deductible or Out-of-Pocket limit.
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 with HSA Fund

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 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 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 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.

Health Savings Account
This plan, with an HSA Fund, is not a Health Savings Account (HSA), but it instead is a health insurance plan intended to be paired with an HSA. The HSA is provided to you directly by a separate HSA Administrator. An HSA is a savings vehicle for medical care expenses. It helps to pay the expenses that insurance does not pay. Individuals and employers can contribute money into an HSA on a tax-deductible or pre-tax basis for individuals. If used to pay for qualified health care expenses, your HSA account's growth and use is tax-free. In addition, HSAs roll over from year to year and are fully portable if an individual changes jobs. HSAs can only be opened by and contributed to on behalf of individuals who are covered under a qualified High Deductible Health Plan (HDHP). For more information on your HSA eligibility if you have other, additional health coverage, consult your tax advisor.

Plan codes: PB91534 R050890 MP51900 SP45000 C000100 V000100 D000100
Facets codes: MED-MS001615 (base) DRU-_____
Billing arrangement: ee, ee+spouse, ee+children, fam

Benefit Booklet

for

BlueOptions®

An Independent Licensee of the Blue Cross and Blue Shield Association

L1338, 7/13

BENEFIT BOOKLET

EMPLOYEE health plan (the PLAN). Blue Cross and Blue Shield of North Carolina provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Please read this benefit booklet carefully.

The benefit plan described in this booklet is an EMPLOYEE health benefit plan, subject to the Employee Retirement Income Security Act of 1974 (ERISA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A summary of benefits, conditions, limitations and exclusions is set forth in this benefit booklet for easy reference.

In the event of a conflict between this benefit booklet and the terms in the PLAN document, the PLAN document will control.

Amendment and/or Termination of the PLAN

The PLAN SPONSOR expects this PLAN to be continued indefinitely, but the PLAN SPONSOR reserves the right to terminate the PLAN at any time with respect to its EMPLOYEES by a written instrument signed by an officer of the PLAN SPONSOR. Such termination may be made without the consent of the MEMBERS, or any other persons. The PLAN SPONSOR also reserves the right to amend the PLAN, including reduction or elimination of benefits or COVERED SERVICES. Amendments shall be made only in accordance with the provisions of the PLAN. The PLAN ADMINISTRATOR will provide notice to MEMBERS within sixty days of the adoption of any amendment that results in a material reduction in COVERED SERVICES or benefits.

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Recent Changes

This section lists recent changes, which may include additions, deletions or revisions to your benefit booklet. These changes supersede language that appears elsewhere in your benefit booklet.

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GETTING STARTED WITH BLUE OPTIONS

IMPORTANT INFORMATION REGARDING THE PLAN:

In accordance with applicable federal law, the PLAN will not discriminate against any health care PROVIDER acting within the scope of their license or certification, or against any person who has received a break on their premium, or taken any other action to endorse his or her right under applicable federal law. Further, the PLAN shall not impose eligibility rules or variations in premiums based on any specified health status-related factors unless specifically permitted by law.

Getting Started

This benefit booklet provides important information about your benefits and can help you understand how to maximize them. It's important that you read the entire booklet. If you need help or more information, it tells you how to contact us in the "Who to Contact" section.

Notes on Words

As you read this benefit booklet, keep in mind that any word you see in "small capital letters (SMALL CAPITAL LETTERS)" is a defined term and appears in the "Glossary" at the end of this benefit booklet.

This Booklet

This booklet tells you about:

- Your COVERED SERVICES and exclusions or services that are not covered
- How the PLAN works.
- How we share expenses for COVERED SERVICES
- Who is eligible to be covered under the PLAN and when this coverage starts and ends
- Our UTILIZATION MANAGEMENT programs and the right to appeal the decision
- Any Special Programs that may come with the PLAN.

PRIOR REVIEW and CERTIFICATION

Certain services require PRIOR REVIEW and CERTIFICATION in order for you to avoid a penalty. General categories of services requiring PRIOR REVIEW and CERTIFICATION are noted in "COVERED SERVICES." To determine if a specific service requires PRIOR REVIEW and CERTIFICATION, visit **www.BlueCrossNC.com** for the PRIOR REVIEW list, which is updated when new services are added or when services are removed. You can also call Blue Cross NC Customer Service. See "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for information about the review process.

Exclusions and Limitations

Exclusions and limitations apply to your coverage. Service-specific exclusions are stated along with the benefit description in "COVERED SERVICES." Exclusions that apply to many services are listed in "What Is Not Covered?" To understand the exclusions and limitations that apply to each service, read "COVERED SERVICES," "Summary of Benefits" and "What Is Not Covered?"

No Assignment of Benefits

The benefits described in this benefit booklet are provided only for MEMBERS. These benefits, the right to receive payment under the PLAN, and the right to enforce any claim arising under the PLAN cannot be transferred or assigned to any other person or entity, including PROVIDERS. Blue Cross NC will not recognize any such assignment, and any attempted assignment is void if performed without Blue Cross NC's prior written consent. PROVIDERS are not considered beneficiaries under the PLAN and do not have standing to sue under ERISA. Blue Cross NC may pay a PROVIDER directly. For example, Blue Cross NC pays IN-NETWORK PROVIDERS directly under applicable contracts with those PROVIDERS. However, any PROVIDER'S right to be paid directly is through such contract with Blue Cross NC, and not through the PLAN. Under the PLAN, Blue Cross NC has the sole right to determine whether payment for services is made to the PROVIDER, to the SUBSCRIBER, or allocated among both. Blue Cross NC's decision to pay a PROVIDER directly in no way reflects or creates any rights of the PROVIDER under the PLAN, including but not limited to benefits, payments or procedures. For more information see "Additional Terms of Your Coverage."

More Information upon Request

You may receive, upon request, information about Blue Options, its services and DOCTORS, including printed copies of this benefit booklet with a benefit summary, and a directory of IN-NETWORK PROVIDERS.

Medical and Reimbursement Policies

Certain services are covered pursuant to Blue Cross NC medical and reimbursement policies, which are updated throughout the plan year. These policies describe the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is MEDICALLY NECESSARY and eligible for coverage, INVESTIGATIONAL or EXPERIMENTAL, COSMETIC, or a convenience item. The most up-to-date medical and reimbursement policies are available at **www.BlueCrossNC.com/content/services/medical-policy/index.htm**, or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

Reduced or Waived Payments

- From time to time, MEMBERS may receive a reduced or waived copayment, deductible and/or coinsurance on designated services, therapies, or PRESCRIPTION DRUGS in connection with programs designed to reduce medical costs, or to encourage

MEMBERS to seek appropriate, high quality, efficient care based on Blue Cross NC criteria.

Common Insurance Terms

To help you become familiar with some common insurance terms concerning what you may owe after visiting your PROVIDER, see the chart below and the "Glossary:"

Copayment	The fixed dollar amount you must pay for some COVERED SERVICES at the time you receive them. Copayments are not credited to the deductible; however, they are credited to the OUT-OF-POCKET LIMIT.
Deductible	The amount of money you must pay for COVERED SERVICES in a BENEFIT PERIOD before the PLAN begins to pay for COVERED SERVICES. The deductible does not include coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum, or charges for noncovered services.
Coinsurance	Your share of the cost of a covered health service, after you have met your BENEFIT PERIOD deductible. This is stated as a percentage of the ALLOWED AMOUNT. The coinsurance listed is your share of the cost of a COVERED SERVICE.
OUT-OF-POCKET LIMIT	The OUT-OF-POCKET LIMIT is the dollar amount you pay for COVERED SERVICES in a BENEFIT PERIOD before the PLAN pays 100% for COVERED SERVICES in a BENEFIT PERIOD. The OUT-OF-POCKET LIMIT includes your deductible, coinsurance, and copayments. It does not include charges over the ALLOWED AMOUNT, including any charges over the allowable cost difference between GENERIC and BRAND-NAME drugs, premiums, and charges for noncovered services.

Please note: This health benefit plan was not specifically designed to be a high deductible health plan ("HDHP") under the Tax Code, and therefore is not intended to be paired with a health savings account ("HSA"). Check with a tax advisor to ensure qualification before you pair this health benefit plan with an HSA.

For Help in Reading this Benefit Booklet

Blue Cross NC provides consumer assistance tools and services for individuals living with disabilities (including accessible websites and the provision of auxiliary aids and services at no cost to the individual) in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. Blue Cross NC also provides language services at no cost to the individual, including oral interpretation and written translations. To access these services and more, call 1-888-206-4697. For TTY and TDD, call 1-800-442-7028.

WHO TO CONTACT?

Toll-Free Phone Numbers, Website and Addresses

Blue Cross NC Website: **www.BlueCrossNC.com**	Find IN-NETWORK PROVIDERS (including pharmacies), and get information about top-performing facilities, PRESCRIPTION DRUG information, and news about Blue Cross NC.
Blue Connect Website: **www.BlueConnectNC.com**	Use our secure MEMBER website to look at your plan, check benefits, eligibility, and claims status, download forms, manage your account, ask for new ID CARDS, get helpful wellness information and more.
Blue Cross NC Customer Service: 1-800-621-8876 TTY/TDD: 1-800-442-7028	For questions about your benefits, claims, new ID CARD requests or to voice a complaint.
PRESCRIPTION DRUG Information: 1-800-621-8876 and **www.BlueCrossNC.com/umdrug**	You may visit Blue Cross NC's website or call Blue Cross NC Customer Service to access a list of IN-NETWORK pharmacies (including the Specialty Network); a list of PRESCRIPTION DRUGS that are subject to PRIOR REVIEW, quantity or benefit limitations; or a copy of the FORMULARY. You may also visit **www.BlueCrossNC.com/umdrug** for more information.
PRIOR REVIEW and CERTIFICATION: To request, MEMBERS call: 1-800-621-8876 PROVIDERS call: 1-800-672-7897	Some services need PRIOR REVIEW and CERTIFICATION from Blue Cross NC. Up-to-date information about which services may need PRIOR REVIEW can be found online at **www.BlueConnectNC.com.**
Behavioral Health: 1-800-359-2422	For questions about your mental health and substance use disorder benefits and claims.
Out of North Carolina Care: 1-800-810-BLUE (2583)	For help in obtaining care outside of North Carolina or the U.S., call this number or visit **www.BCBS.com.**
Medical Claims Filing: Blue Cross NC Claims Department PO Box 35 Durham, NC 27702-0035	Mail completed medical claims to this address.

WHO TO CONTACT? *(cont.)*

PRESCRIPTION DRUG Claims Filing: Prime Therapeutics Mail Route: Commercial Blue Cross NC PO Box 25136 Lehigh Valley, PA 18002-5136	Mail completed PRESCRIPTION DRUG claims to this address.

Value-Added Programs

Not all plans have these Value-Added programs. These programs are not covered benefits and are outside of the PLAN. To see if these programs are available, talk to your PLAN ADMINISTRATOR. Blue Cross NC does not accept claims or reimburse for these goods or services and MEMBERS are responsible for paying all bills. The PLAN ADMINISTRATOR and Blue Cross NC may change or discontinue these programs at any time.

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Staying healthy and active should be easy – and affordable. That's why Blue Cross NC offers Blue365™. It's a simple way to save on everything you need for a well-balanced lifestyle.

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Or call 1-855-511-BLUE (2583)

SUMMARY OF BENEFITS

This section provides a summary of your Blue Options benefits. A more complete description of your benefits is found in "COVERED SERVICES." General exclusions may also apply—please see "What Is Not Covered?" As you review the "Summary of Benefits" chart, keep in mind:

- Multiple OFFICE VISITS or emergency room visits on the same day may result in multiple copayments
- Coinsurance percentages shown in this section are the part that you pay for COVERED SERVICES
- Amounts applied to deductible and coinsurance are based on the ALLOWED AMOUNT
- Amounts applied to the deductible also count toward any visit or day maximums for those services
- Benefits may differ depending on where the service is performed and if the service is received with any other service or associated with a surgical procedure.
- If your benefit level for services includes deductible or coinsurance, your PROVIDER may collect an estimated amount of these at the time you receive services.
- To receive IN-NETWORK benefits, you must receive care from a Blue Options IN-NETWORK PROVIDER. However, in an EMERGENCY, you may receive care from an IN-NETWORK or OUT-OF-NETWORK PROVIDER. Please see "EMERGENCY and Ambulance Services" in "COVERED SERVICES" for additional information on EMERGENCY care.

Please Note: The list of IN-NETWORK PROVIDERS may change from time to time, so please verify that the PROVIDER is still in the Blue Options network before receiving care. Find a PROVIDER on Blue Cross NC's website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service at the number listed on your ID CARD or in "Who to Contact?"

BENEFIT PERIOD—01/01/2023 through 12/31/2023

Benefit payments are based on where services are received and how services are billed.

Benefits	IN-NETWORK	OUT-OF-NETWORK
Deductibles, OUT-OF-POCKET LIMITS and Benefit Maximums		
The following deductibles and maximums apply to the services listed below in the "Summary of Benefits" unless otherwise noted.		
Deductible		
Individual, per BENEFIT PERIOD	$500	$1,000
Family, per BENEFIT PERIOD	$1,000	$2,000
The PLAN has an embedded deductible which means MEMBERS must meet their individual deductible before COVERED SERVICES are paid according to the benefits under this PLAN. If DEPENDENTS are covered, you also have a combined family deductible. However, once the family deductible is met, COVERED SERVICES will be paid according to the benefits for all family MEMBERS. Amounts applied to your OUT-OF-NETWORK deductible are credited to your IN-NETWORK deductible. Amounts applied to your IN-NETWORK deductible are credited to your OUT-OF-NETWORK deductible.		
OUT-OF-POCKET LIMIT		
Individual, per BENEFIT PERIOD	$1,500	$3,000
Family, per BENEFIT PERIOD	$3,000	$6,000
The PLAN has an embedded individual OUT-OF-POCKET LIMIT and if DEPENDENTS are covered, you also have a combined family OUT-OF-POCKET LIMIT. Once a MEMBER meets their individual OUT-OF-POCKET LIMIT the PLAN will pay 100% of the ALLOWED AMOUNT for COVERED SERVICES for that individual. Once the family OUT-OF-POCKET LIMIT is met, it is met for all MEMBERS. Charges applied to your OUT-OF-NETWORK OUT-OF-POCKET LIMIT are credited to your IN-NETWORK OUT-OF-POCKET LIMIT. Amounts applied to your IN-NETWORK OUT-OF-POCKET LIMIT are credited to your OUT-OF-NETWORK OUT-OF-POCKET LIMIT.		
LIFETIME MAXIMUMS per MEMBER	Unlimited	
Unlimited for all services unless otherwise noted below. Maximums are combined IN- and OUT-OF-NETWORK, unless noted otherwise. If you exceed any LIFETIME		

Benefits	IN-NETWORK	OUT-OF-NETWORK
MAXIMUM, additional services of that type are not covered. In this case, you may be responsible for the entire amount of the PROVIDER'S billed charge.		
Orthotic Devices for POSITIONAL PLAGIOCEPHALY	One device	
Vein Treatment	Endovenous or microfoam-sclerotherapy procedures—one procedure per limb. Liquid-sclerotherapy tributary vein treatment—three procedures per limb	
BENEFIT MAXIMUMS per MEMBER		
Maximums are per BENEFIT PERIOD and combined IN- and OUT-OF-NETWORK, unless noted otherwise. Any services in excess of these benefit maximums are not COVERED SERVICES. All day and visit limits are for IN- and OUT-OF-NETWORK benefits combined.		
Breast Pump and Supplies (per pregnancy)	Limit of one (1) manual or electric pump. Limit of two (2) each for supplies including but not limited to, tubing, shields and bottles. See **www.BlueCrossNC.com/preventive** for more information.	
Dialysis Treatment	Three (3) hemodialysis treatments per week, more hemodialysis treatments are available if MEDICALLY NECESSARY	
Evaluation and Treatment of Obesity	Four visits, applies to office and outpatient setting. These visits are separate from any nutritional counseling visits, if applicable.	
Hearing Aids	When covered, one hearing aid per hearing-impaired ear every 36 months	
Home Health Care	100 days (combined with private duty nursing)	
Nutritional Counseling	10 visits Visit limits apply to MENTAL ILLNESS diagnoses.	
Private Duty Nursing	100 days (combined with home health care)	
REHABILITATIVE THERAPY and HABILITATIVE	60 visits for physical/occupational therapy. 30 visits for speech therapy. 12 visits for chiropractic services. Visit limits apply to MENTAL ILLNESS diagnoses.	

Benefits	IN-NETWORK	OUT-OF-NETWORK
SERVICES (applies to home, office and outpatient setting)		
SKILLED NURSING FACILITY	100 days	
PREVENTIVE CARE		
Available in an office-based, outpatient, ambulatory surgical setting, or URGENT CARE centers. This benefit is only for services that indicate a primary diagnosis of preventive or wellness. See "PREVENTIVE CARE" in "COVERED SERVICES." Please visit Blue Cross NC's website at **www.BlueCrossNC.com/preventive** for the most up-to-date information on PREVENTIVE CARE covered under federal law.		
Screenings	No Charge	50%
Includes: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.		
Other PREVENTIVE CARE (federally mandated)	No Charge	50%
For a list of PREVENTIVE CARE services that are covered under federal law, see Blue Cross NC's website at **www.BlueCrossNC.com/preventive** or call Blue Cross NC Customer Service at the number in "Who to Contact?"		
Please note that the following services are also covered at No Charge IN-NETWORK: nutritional counseling visits, regardless of diagnosis (are also available OUT-OF-NETWORK at 50%).		
PROVIDER'S Office		
See Outpatient for OUTPATIENT CLINIC or HOSPITAL-based services.		
OFFICE VISIT Services		
PRIMARY CARE PROVIDER	$30 copayment	50% after deductible
SPECIALIST	$40 copayment	50% after deductible
Includes: all OFFICE VISITS for medical, therapy services, pre-natal/post-delivery care (not included in the global maternity delivery fee), office SURGERY, allergy shots, allergy tests and treatments, x-rays and lab tests. Also included are infusion services received at an AMBULATORY INFUSION SUITE. If you see your PCP for mental health or substance use disorder related services, these services are included as well.		

Benefits	IN-NETWORK	OUT-OF-NETWORK
Onsite Clinic - Premise Health	$10 copayment	
Independent Labs	10% after deductible	50% after deductible
Respiration Therapy, Dialysis, Cardiac Rehabilitation	10% after deductible	50% after deductible
Chemotherapy, Radiation, Inhalation, Dialysis, IV Therapy, Shock & Cardiac therapy	$40 copayment	50% after deductible
EMERGENCY and Ambulance Services		
EMERGENCY SERVICES	$150 copayment	$150 copayment
If you are sent to the emergency room from an URGENT CARE center, you may be responsible for both the emergency room copayment and the URGENT CARE copayment.		
Ambulance Services	10% after deductible	10% after deductible
See "COVERED SERVICES" for more information regarding coverage of EMERGENCY and air ambulance services.		
URGENT CARE Centers		
URGENT CARE	$40 copayment	50% after deductible
AMBULATORY SURGICAL CENTER		
Ambulatory Surgical Services	10% after deductible	50% after deductible
Outpatient		
Physician Services	10% after deductible	50% after deductible
HOSPITAL and HOSPITAL-based and OUTPATIENT CLINIC Services	10% after deductible	50% after deductible
Outpatient Diagnostic Services		
Outpatient lab tests, x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	10% after deductible	50% after deductible

Benefits	IN-NETWORK	OUT-OF-NETWORK
Outpatient diagnostic mammography (physician and HOSPITAL-based services)	No Charge	50% after deductible
See PREVENTIVE CARE for coverage of screening mammograms. NOTE: When a MEMBER appeals a no PA denial for an outpatient service, the claim will be reviewed for MEDICAL NECESSITY. If determined MEDICAL NECESSITY, the denial will be overturned and paid according to benefits. If determined not to be MEDICAL NECESSITY, the claim will deny as not MEDICAL NECESSITY.		
Inpatient		
Physician Services	10% after deductible	50% after deductible
HOSPITAL and HOSPITAL-based Services	10% after deductible	50% after deductible
Includes inpatient HOSPITAL services, including, but not limited to medical, therapies, transplants (covered at Blue Distinction Centers only), maternity delivery, and surgeries. If you are in a HOSPITAL as an inpatient at the time you begin a new BENEFIT PERIOD, you may have to meet a new deductible for COVERED SERVICES from DOCTORS or OTHER PROFESSIONAL PROVIDERS.		
SKILLED NURSING FACILITY		
Skilled Nursing Facility	10% after deductible	50% after deductible
Other Services		
Home Health care, HOSPICE and private duty nursing	10% after deductible	50% after deductible
DURABLE MEDICAL EQUIPMENT MEDICAL SUPPLIES, orthotic devices, PROSTHETIC APPLIANCES	10% after deductible	50% after deductible
CT Scans, MRIs, MRAs and PET scans in any location, including a physician's office	10% after deductible	50% after deductible
Wigs	10% after deductible	10% after deductible
Mental Health and Substance Use Disorder Services		
Mental Health Office Services	$40 copayment	50% after deductible

Benefits	IN-NETWORK	OUT-OF-NETWORK
Mental Health Inpatient Services		
Physician Services	10% after deductible	50% after deductible
HOSPITAL and HOSPITAL-based, including RESIDENTIAL TREATMENT FACILITY, Services	10% after deductible	50% after deductible
Mental Health Outpatient Services		
Physician Services	10% after deductible	50% after deductible
HOSPITAL and HOSPITAL-based Services	10% after deductible	50% after deductible
Substance Use Disorder Office Services	$40 copayment	50% after deductible
Substance Use Disorder Inpatient Services		
Physician Services	10% after deductible	50% after deductible
HOSPITAL and HOSPITAL-based, including RESIDENTIAL TREATMENT FACILITY, Services	10% after deductible	50% after deductible
Substance Use Disorder Outpatient Services		
Physician Services	10% after deductible	50% after deductible
HOSPITAL and HOSPITAL-based Services	10% after deductible	50% after deductible
CERTIFICATION Requirements		
Certain services require PRIOR REVIEW and CERTIFICATION by the PLAN in order to receive benefits. See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information. Blue Cross NC delegates PRIOR REVIEW and CERTIFICATION for particular benefits to other companies not associated with Blue Cross NC. Please see **https://www.BlueCrossNC.com/content/services/medical-policy/index.htm** for a detailed list of these		

companies and benefits. While some benefits have been identified under "COVERED SERVICES," the list of benefits and/or companies may change from time to time; for the most up-to-date information visit **https://www.BlueCrossNC.com/content/services/medical-policy/index.htm.**

PRESCRIPTION DRUGS		
Benefits	**IN-NETWORK**	**OUT-OF-NETWORK**
Note: You may pay a different amount than listed below if you choose a BRAND-NAME PRESCRIPTION DRUG instead of a GENERIC PRESCRIPTION DRUG. If your PROVIDER requires you to take, or 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. 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 PROVIDER required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Your PROVIDER must submit a Request for Waiver of Brand Drug for approval. Find more information at **https://www.BlueCrossNC.com/umdrug.** Applicable copayment or coinsurance amounts would still apply.		
TIER 1 DRUGS	$10 copayment	**Benefits not available**
TIER 2 DRUGS	$10 copayment	**Benefits not available**
TIER 3 DRUGS	$30 copayment	**Benefits not available**
TIER 4 DRUGS	$70 copayment	**Benefits not available**
TIER 5 DRUGS	20%	**Benefits not available**
Diabetic Supplies, Spacers and Peak Flow Meters	$30 copayment	**Benefits not available**
One copayment for up to a 30-day supply. 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 $150. Mail order drugs are 2 copayments for a 90 day maintenance supply. Any OUT-OF-NETWORK charges over the ALLOWED AMOUNT are not included in this maximum. Also see Net Results FORMULARY at **http://www.bcbsnc.com/netresults5tierC** . Please note: During a government issued public health emergency, the MEMBER expense may change for certain PRESCRIPTION DRUGS, reducing the out-of-pocket cost to		

Benefits	IN-NETWORK	OUT-OF-NETWORK
the MEMBER. Find more information at **www.bluecrossnc.com/understanding-insurance/how-drug-benefits-work/copayment-tier-definitions.**		
Preventive over-the-counter medications and PRESCRIPTION contraceptive drugs and devices as listed at www.BlueCrossNC.com/preventive*	No Charge	No Charge**
*Please visit the website at **www.BlueCrossNC.com/preventive** or call Blue Cross NC Customer Service for guidelines on which preventive over-the-counter medications are covered and individuals who may qualify, as well as more information and any limitations that apply for contraceptives. PRESCRIPTION contraceptive drugs and devices that are not covered at the PREVENTIVE CARE benefit level will be covered according to your regular PRESCRIPTION DRUG benefits. Also see "PREVENTIVE CARE" in "COVERED SERVICES." **No Charge indicates no obligation for MEMBERS to pay any portion of the ALLOWED AMOUNT. For OUT-OF-NETWORK benefits, you may be required to pay for charges over the ALLOWED AMOUNT, the difference between the ALLOWED AMOUNT and the billed charge.		

Benefit Booklet

For Employees of Town

for

BlueOptions®

BlueCross BlueShield of North Carolina

An Independent Licensee of the Blue Cross and Blue Shield Association

L1338, 7/13

BENEFIT BOOKLET

EMPLOYEE health plan (the PLAN).

Blue Cross and Blue Shield of North Carolina provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Please read this benefit booklet carefully.

The benefit plan described in this booklet is an EMPLOYEE health benefit plan, subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A summary of benefits, conditions, limitations and exclusions is set forth in this benefit booklet for easy reference.

In the event of a conflict between this benefit booklet and the terms in the PLAN document, the PLAN document will control.

Amendment and/or Termination of the PLAN

The PLAN ADMINISTRATOR expects this PLAN to be continued indefinitely, but the PLAN ADMINISTRATOR reserves the right to terminate the PLAN at any time with respect to its EMPLOYEES by a written instrument signed by an officer of the PLAN ADMINISTRATOR. Such termination may be made without the consent of the MEMBERS, or any other persons. The PLAN ADMINISTRATOR also reserves the right to amend the PLAN, including reduction or elimination of benefits or COVERED SERVICES. Amendments shall be made only in accordance with the provisions of the PLAN. The PLAN ADMINISTRATOR will provide notice to MEMBERS within sixty days of the adoption of any amendment that results in a material reduction in COVERED SERVICES or benefits.

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Recent Changes

This section lists recent changes, which may include additions, deletions or revisions to your benefit booklet. These changes supersede language that appears elsewhere in your benefit booklet.

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GETTING STARTED WITH BLUE OPTIONS

IMPORTANT INFORMATION REGARDING THE PLAN:

In accordance with applicable federal law, the PLAN will not discriminate against any health care PROVIDER acting within the scope of their license or certification, or against any person who has received a break on their premium, or taken any other action to endorse his or her right under applicable federal law. Further, the PLAN shall not impose eligibility rules or variations in premiums based on any specified health status-related factors unless specifically permitted by law.

Getting Started

This benefit booklet provides important information about your benefits and can help you understand how to maximize them. It's important that you read the entire booklet. If you need help or more information, it tells you how to contact us in the "Who to Contact" section.

Notes on Words

As you read this benefit booklet, keep in mind that any word you see in "small capital letters (SMALL CAPITAL LETTERS)" is a defined term and appears in the "Glossary" at the end of this benefit booklet.

This Booklet

This booklet tells you about:

- Your COVERED SERVICES and exclusions or services that are not covered
- How the PLAN works
- How we share expenses for COVERED SERVICES
- Who is eligible to be covered under the PLAN and when this coverage starts and ends
- Our UTILIZATION MANAGEMENT programs and the right to appeal the decision
- Any Special Programs that may come with the PLAN.

PRIOR REVIEW and CERTIFICATION

Certain services require PRIOR REVIEW and CERTIFICATION in order for you to avoid a full denial of benefits. General categories of services requiring PRIOR REVIEW and CERTIFICATION are noted in "COVERED SERVICES." To determine if a specific service requires PRIOR REVIEW and CERTIFICATION, visit **www.BlueCrossNC.com** for the PRIOR REVIEW list, which is updated when new services are added or when services are removed. You can also call Blue Cross NC Customer Service. See "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for information about the review process.

Exclusions and Limitations

Exclusions and limitations apply to your coverage. Service-specific exclusions are stated along with the benefit description in "COVERED SERVICES." Exclusions that apply to many services are listed in "What Is Not Covered?" To understand the exclusions and limitations that apply to each service, read "COVERED SERVICES," "Summary of Benefits" and "What Is Not Covered?"

No Assignment of Benefits

The benefits described in this benefit booklet are provided only for MEMBERS. These benefits, the right to receive payment under the PLAN, and the right to enforce any claim arising under the PLAN cannot be transferred or assigned to any other person or entity, including PROVIDERS. Blue Cross NC will not recognize any such assignment, and any attempted assignment is void if performed without Blue Cross NC's prior written consent. PROVIDERS are not considered beneficiaries under the PLAN and do not have standing to sue under ERISA. Blue Cross NC may pay a PROVIDER directly. For example, Blue Cross NC pays IN-NETWORK PROVIDERS directly under applicable contracts with those PROVIDERS. However, any PROVIDER'S right to be paid directly is through such contract with Blue Cross NC, and not through the PLAN. Under the PLAN, Blue Cross NC has the sole right to determine whether payment for services is made to the PROVIDER, to the SUBSCRIBER, or allocated among both. Blue Cross NC's decision to pay a PROVIDER directly in no way reflects or creates any rights of the PROVIDER under the PLAN, including but not limited to benefits, payments or procedures. For more information see "Additional Terms of Your Coverage."

More Information upon Request

You may receive, upon request, information about Blue Options, its services and DOCTORS, including printed copies of this benefit booklet with a benefit summary, and a directory of IN-NETWORK PROVIDERS.

Medical and Reimbursement Policies

Certain services are covered pursuant to Blue Cross NC medical and reimbursement policies, which are updated throughout the plan year. These policies describe the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is MEDICALLY NECESSARY and eligible for coverage, INVESTIGATIONAL or EXPERIMENTAL, COSMETIC, or a convenience item. The most up-to-date medical and reimbursement policies are available at **www.BlueCrossNC.com/content/services/medical-policy/index.htm**, or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

Reduced or Waived Payments

- From time to time, MEMBERS may receive a reduced or waived copayment, deductible and/or coinsurance on designated services, therapies, or PRESCRIPTION DRUGS in connection with programs designed to reduce medical costs, or to encourage

MEMBERS to seek appropriate, high quality, efficient care based on Blue Cross NC criteria.

Common Insurance Terms

To help you become familiar with some common insurance terms concerning what you may owe after visiting your PROVIDER, see the chart below and the "Glossary:"

Copayment	The fixed dollar amount you must pay for some COVERED SERVICES at the time you receive them. Copayments are not credited to the deductible; however, they are credited to the OUT-OF-POCKET LIMIT.
Deductible	The amount of money you must pay for COVERED SERVICES in a BENEFIT PERIOD before the PLAN begins to pay for COVERED SERVICES. The deductible does not include coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum, or charges for noncovered services.
Coinsurance	Your share of the cost of a covered health service, after you have met your BENEFIT PERIOD deductible. This is stated as a percentage of the ALLOWED AMOUNT. The coinsurance listed is your share of the cost of a COVERED SERVICE.
OUT-OF-POCKET LIMIT	The OUT-OF-POCKET LIMIT is the dollar amount you pay for COVERED SERVICES in a BENEFIT PERIOD before the PLAN pays 100% for COVERED SERVICES in a BENEFIT PERIOD. The OUT-OF-POCKET LIMIT includes your deductible, coinsurance, and copayments. It does not include charges over the ALLOWED AMOUNT, including any charges over the allowable cost difference between GENERIC and BRAND-NAME drugs, premiums, and charges for noncovered services.

Please note: This health benefit plan was not specifically designed to be a high deductible health plan ("HDHP") under the Tax Code, and therefore is not intended to be paired with a health savings account ("HSA"). Check with a tax advisor to ensure qualification before you pair this health benefit plan with an HSA.

For Help in Reading this Benefit Booklet

Blue Cross NC provides consumer assistance tools and services for individuals living with disabilities (including accessible websites and the provision of auxiliary aids and services at no cost to the individual) in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. Blue Cross NC also provides language services at no cost to the individual, including oral interpretation and written translations. To access these services and more, call 1-888-206-4697. For TTY and TDD, call 1-800-442-7028.

WHO TO CONTACT?

Toll-Free Phone Numbers, Website and Addresses

Blue Cross NC Website: **www.BlueCrossNC.com**	Find IN-NETWORK PROVIDERS (including pharmacies), and get information about top-performing facilities, PRESCRIPTION DRUG information, and news about Blue Cross NC.
Blue Connect Website: **www.BlueConnectNC.com**	Use our secure MEMBER website to look at your plan, check benefits, eligibility, and claims status, download forms, manage your account, ask for new ID CARDS, get helpful wellness information and more.
Blue Cross NC Customer Service: 1-877-275-9787 TTY/TDD: 1-800-442-7028	For questions about your benefits, claims, new ID CARD requests or to voice a complaint.
PRESCRIPTION DRUG Information: 1-877-275-9787 and **www.BlueCrossNC.com/umdrug**	You may visit Blue Cross NC's website or call Blue Cross NC Customer Service to access a list of IN-NETWORK pharmacies (including the Specialty Network); a list of PRESCRIPTION DRUGS that are subject to PRIOR REVIEW, quantity or benefit limitations; or a copy of the FORMULARY. You may also visit **www.BlueCrossNC.com/umdrug** for more information.
PRIOR REVIEW and CERTIFICATION: To request, MEMBERS call: 1-877-275-9787 PROVIDERS call: 1-800-672-7897	Some services need PRIOR REVIEW and CERTIFICATION from Blue Cross NC. Up-to-date information about which services may need PRIOR REVIEW can be found online at **www.BlueConnectNC.com.**
Behavioral Health: 1-800-359-2422	For questions about your mental health and substance use disorder benefits and claims.
Out of North Carolina Care: 1-800-810-BLUE (2583)	For help in obtaining care outside of North Carolina or the U.S., call this number or visit **www.bcbs.com.**
Nurse Support: 1-888-229-8510	Talk to a Nurse Advocate about receiving support for managing asthma, diabetes, congestive heart failure, coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD), or hypertension. Please talk to your PLAN ADMINISTRATOR to see if this program is available to you.

My Pregnancy: **www.BCBSNC.com/mypregnancy**	The maternity program will provide you with support for managing your pregnancy. Please talk to your PLAN ADMINISTRATOR to see if this program is available to you.
Wellness Coaching: 1-888-292-5444	Wellness coaches provide behavioral support to help you manage lifestyle issues. Wellness support is available by phone, as well as by e-mail and live chat. Please talk to your PLAN ADMINISTRATOR to see if this program is available to you.
Medical Claims Filing: Blue Cross NC Claims Department PO Box 35 Durham, NC 27702-0035	Mail completed medical claims to this address.
PRESCRIPTION DRUG Claims Filing: Prime Therapeutics Mail Route: Commercial Blue Cross NC PO Box 25136 Lehigh Valley, PA 18002-5136	Mail completed PRESCRIPTION DRUG claims to this address.

Value-Added Programs

Not all plans have these Value-Added programs. These programs are not covered benefits and are outside of the PLAN. To see if these programs are available, talk to your PLAN ADMINISTRATOR. Blue Cross NC does not accept claims or reimburse for these goods or services and MEMBERS are responsible for paying all bills. The PLAN ADMINISTRATOR and Blue Cross NC may change or discontinue these programs at any time.

Blue365™

Keep your body – and budget – healthy

Staying healthy and active should be easy – and affordable. That's why Blue Cross NC offers Blue365™. It's a simple way to save on everything you need for a well-balanced lifestyle.

Get deals, discounts & more:

- Fitness: Gym memberships & fitness gear
- Personal Care: Vision & hearing care
- Healthy Eating: Weight loss & nutrition programs
- Lifestyle: Travel & family activities
- Wellness: Mind/body wellness tools & resources
- Financial Health: Financial tools & programs

WHO TO CONTACT? *(cont.)*

Join and save

Visit **www.BlueCrossNC.com/blue365**

Or call 1-855-511-BLUE (2583)

SUMMARY OF BENEFITS

This section provides a summary of your Blue Options benefits. A more complete description of your benefits is found in "COVERED SERVICES." General exclusions may also apply—please see "What Is Not Covered?" As you review the "Summary of Benefits" chart, keep in mind:

- Multiple OFFICE VISITS or emergency room visits on the same day may result in multiple copayments
- Coinsurance percentages shown in this section are the part that you pay for COVERED SERVICES
- Amounts applied to deductible and coinsurance are based on the ALLOWED AMOUNT
- Amounts applied to the deductible also count toward any visit or day maximums for those services
- Benefits may differ depending on where the service is performed and if the service is received with any other service or associated with a surgical procedure.
- If your benefit level for services includes deductible or coinsurance, your PROVIDER may collect an estimated amount of these at the time you receive services.
- To receive IN-NETWORK benefits, you must receive care from a Blue Options IN-NETWORK PROVIDER. However, in an EMERGENCY, you may receive care from an IN-NETWORK or OUT-OF-NETWORK PROVIDER. Please see "EMERGENCY and Ambulance Services" in "COVERED SERVICES" for additional information on EMERGENCY care.

Please Note: The list of IN-NETWORK PROVIDERS may change from time to time, so please verify that the PROVIDER is still in the Blue Options network before receiving care. Find a PROVIDER on Blue Cross NC's website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service at the number listed on your ID CARD or in "Who to Contact?"

BENEFIT PERIOD—07/01/2023 through 06/30/2024

Benefit payments are based on where services are received and how services are billed.

Benefits	IN-NETWORK	OUT-OF-NETWORK
Deductibles, OUT-OF-POCKET LIMITS and Benefit Maximums		
The following deductibles and maximums apply to the services listed below in the "Summary of Benefits" unless otherwise noted.		
Deductible		
Individual, per BENEFIT PERIOD	$500	$1,000
Family, per BENEFIT PERIOD	$1,000	$2,000
The PLAN has an embedded deductible which means MEMBERS must meet their individual deductible before COVERED SERVICES are paid according to the benefits under this PLAN. If DEPENDENTS are covered, you also have a combined family deductible. However, once the family deductible is met, COVERED SERVICES will be paid according to the benefits for all family MEMBERS.		
IN-NETWORK services are credited to your IN-NETWORK deductible and OUT-OF-NETWORK services are credited to your OUT-OF-NETWORK deductible.		
OUT-OF-POCKET LIMIT		
Individual, per BENEFIT PERIOD	$2,500	$4,000
Family, per BENEFIT PERIOD	$5,000	$8,000
The PLAN has an embedded individual OUT-OF-POCKET LIMIT and if DEPENDENTS are covered, you also have a combined family OUT-OF-POCKET LIMIT. Once a MEMBER meets their individual OUT-OF-POCKET LIMIT the PLAN will pay 100% of the ALLOWED AMOUNT for COVERED SERVICES for that individual. Once the family OUT-OF-POCKET LIMIT is met, it is met for all MEMBERS.		
Charges for IN-NETWORK services apply to your IN-NETWORK OUT-OF-POCKET LIMIT and charges for OUT-OF-NETWORK services apply to your OUT-OF-NETWORK OUT-OF-POCKET LIMIT.		
LIFETIME MAXIMUMS per MEMBER	Unlimited	
Unlimited for all services unless otherwise noted below. Maximums are combined IN- and OUT-OF-NETWORK, unless noted otherwise. If you exceed any LIFETIME MAXIMUM, additional services of that type are not covered. In this case, you may be responsible for the entire amount of the PROVIDER'S billed charge.		

Benefits	IN-NETWORK	OUT-OF-NETWORK
INFERTILITY PRESCRIPTION DRUGS	Quantity limits apply, see **www.BlueCrossNC.com/umdrug**. PRESCRIPTION DRUGS indicated to treat INFERTILITY will be included in this benefit limit as they are approved by the U.S. Food and Drug Administration (FDA)	
INFERTILITY Services (in any place of service)	Three ovulation induction cycles, with or without insemination.	
Orthotic Devices for POSITIONAL PLAGIOCEPHALY	One device	
Vein Treatment	Endovenous or microfoam-sclerotherapy procedures—one procedure per limb Liquid-sclerotherapy tributary vein treatment—three procedures per limb	
Benefit Maximums per MEMBER		
Maximums are per BENEFIT PERIOD and combined IN- and OUT-OF-NETWORK, unless noted otherwise. Any services in excess of these benefit maximums are not COVERED SERVICES. All day and visit limits are for IN- and OUT-OF-NETWORK benefits combined.		
Breast Pump and Supplies	Limit of one (1) manual or electric pump. Limit of two (2) each for supplies including but not limited to, tubing, shields and bottles. See **www.BlueCrossNC.com/preventive** for more information.	
Dialysis Treatment	Three (3) hemodialysis treatments per week, more hemodialysis treatments are available if MEDICALLY NECESSARY	
Evaluation and Treatment of Obesity	Four visits, applies to office and outpatient setting. These visits are separate from any nutritional counseling visits, if applicable.	
Hearing Aids	When covered, one hearing aid per hearing-impaired ear every 36 months	
Home Health Care	60 days	
Nutritional Counseling	30 visits Visit limits do not apply to MENTAL ILLNESS diagnoses.	
REHABILITATIVE THERAPY and HABILITATIVE SERVICES (applies to home, office and outpatient setting)	30 visits per benefit period for physical/occupational/speech therapy 30 visits per benefit period for chiropractic services	

Benefits	IN-NETWORK	OUT-OF-NETWORK
	Visit limits do not apply to MENTAL ILLNESS diagnoses.	
SKILLED NURSING FACILITY	60 days	
PREVENTIVE CARE		
Available in an office-based, outpatient, ambulatory surgical setting, or URGENT CARE centers. This benefit is only for services that indicate a primary diagnosis of preventive or wellness. See "PREVENTIVE CARE" in "COVERED SERVICES." Please visit Blue Cross NC's website at **www.BlueCrossNC.com/preventive** for the most up-to-date information on PREVENTIVE CARE covered under federal law.		
Screenings	No Charge	30% after deductible
Includes: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.		
Other PREVENTIVE CARE (federally mandated)	No Charge	30% after deductible
For a list of PREVENTIVE CARE services that are covered under federal law, see Blue Cross NC's website at **www.BlueCrossNC.com/preventive** or call Blue Cross NC Customer Service at the number in "Who to Contact?"		
Please note that the following services are also covered at No Charge IN-NETWORK: nutritional counseling visits, regardless of diagnosis (are also available OUT-OF-NETWORK at 30% after deductible).		
PROVIDER'S Office See Outpatient for OUTPATIENT CLINIC or HOSPITAL-based services.		
OFFICE VISIT Services		
PRIMARY CARE PROVIDER	$20 copayment	30% after deductible
SPECIALIST	$40 copayment	30% after deductible
Includes: all OFFICE VISITS for medical, INFERTILITY, therapy services, pre-natal/post-delivery care (not included in the global maternity delivery fee), office SURGERY, x-rays and lab tests. Also included are infusion services received at an AMBULATORY INFUSION SUITE. If you see your PCP for mental health or substance use disorder related services, these services are included as well.		
Retail Walk-in Clinic	$20 copayment	30% after deductible
Telehealth	$10 copayment	Not Applicable

Benefits	IN-NETWORK	OUT-OF-NETWORK
Telehealth services are also available from a local IN-NETWORK or OUT-OF-NETWORK PROVIDER, see "Office Services" in "COVERED SERVICES."		
EMERGENCY and Ambulance Services		
EMERGENCY SERVICES	$150 copayment	$150 copayment
If you are sent to the emergency room from an URGENT CARE center, you may be responsible for both the emergency room copayment and the URGENT CARE copayment.		
Ambulance Services	20% after deductible	20% after deductible
See "COVERED SERVICES" for more information regarding coverage of EMERGENCY and air ambulance services.		
URGENT CARE Centers		
URGENT CARE	$40 copayment	30% after deductible
AMBULATORY SURGICAL CENTER		
Ambulatory Surgical Services	20% after deductible	30% after deductible
Outpatient		
Physician Services	20% after deductible	30% after deductible
HOSPITAL and HOSPITAL-based and OUTPATIENT CLINIC Services	20% after deductible	30% after deductible
Outpatient Diagnostic Services		
Outpatient lab tests, x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	20% after deductible	30% after deductible
Outpatient diagnostic mammography (physician and HOSPITAL-based services)	No Charge	30% after deductible
See PREVENTIVE CARE for coverage of screening mammograms.		
Inpatient		
Physician Services	20% after deductible	30% after deductible
HOSPITAL and HOSPITAL-based Services	20% after deductible	30% after deductible
Includes inpatient HOSPITAL services, including, but not limited to medical, INFERTILITY, therapies, transplants, maternity delivery, and surgeries. If you are in a HOSPITAL as an		

Benefits	IN-NETWORK	OUT-OF-NETWORK
inpatient at the time you begin a new BENEFIT PERIOD, you may have to meet a new deductible for COVERED SERVICES from DOCTORS or OTHER PROFESSIONAL PROVIDERS.		
SKILLED NURSING FACILITY		
SKILLED NURSING FACILITY	20% after deductible	30% after deductible
Other Services		
Home Health care, HOSPICE and private duty nursing	No Charge	30% after deductible
DURABLE MEDICAL EQUIPMENT, MEDICAL SUPPLIES, orthotic devices, PROSTHETIC APPLIANCES	No Charge	30% after deductible
CT Scans, MRIs, MRAs and PET scans in any location, including a physician's office	20% after deductible	30% after deductible
Mental Health and Substance Use Disorder Services		
Mental Health Office Services	$10 copayment	30% after deductible
Mental Health Inpatient Services		
Physician Services	20% after deductible	30% after deductible
HOSPITAL and HOSPITAL-based, including RESIDENTIAL TREATMENT FACILITY, Services	20% after deductible	30% after deductible
Mental Health Outpatient Services		
Physician Services	20% after deductible	30% after deductible
HOSPITAL and HOSPITAL-based Services	20% after deductible	30% after deductible
Substance Use Disorder Office Services	$10 copayment	30% after deductible
Substance Use Disorder Inpatient Services		
Physician Services	20% after deductible	30% after deductible
HOSPITAL and HOSPITAL-based, including	20% after deductible	30% after deductible

Benefits	IN-NETWORK	OUT-OF-NETWORK
RESIDENTIAL TREATMENT FACILITY, Services		
Substance Use Disorder Outpatient Services		
Physician Services	20% after deductible	30% after deductible
HOSPITAL and HOSPITAL-based Services	20% after deductible	30% after deductible
CERTIFICATION Requirements		
Certain services require PRIOR REVIEW and CERTIFICATION by the PLAN in order to receive benefits. See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information. Blue Cross NC delegates PRIOR REVIEW and CERTIFICATION for particular benefits to other companies not associated with Blue Cross NC. Please see **www.BlueCrossNC.com** for a detailed list of these companies and benefits. While some benefits have been identified under "COVERED SERVICES," the list of benefits and/or companies may change from time to time; for the most up-to-date information visit **www.BlueCrossNC.com.**		

PRESCRIPTION DRUGS		
Benefits	**IN-NETWORK**	**OUT-OF-NETWORK**
Note: You may pay a different amount than listed below if you choose a BRAND-NAME PRESCRIPTION DRUG instead of a GENERIC PRESCRIPTION DRUG. 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. 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 PROVIDER required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts would still apply.		
TIER 1 DRUGS	$4 copayment	$4 copayment
TIER 2 DRUGS	$15 copayment	$15 copayment
TIER 3 DRUGS	$30 copayment	$30 copayment
TIER 4 DRUGS	$45 copayment	$45 copayment
TIER 5 DRUGS	25%	25%
Diabetic Supplies, Spacers and Peak Flow Meters	25%	25%
One copayment for up to a 30 day supply. 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 not pay more than $100. Any OUT-OF-NETWORK charges over the ALLOWED AMOUNT are not included in this maximum. Limits apply to INFERTILITY drugs, see "PRESCRIPTION DRUG Benefits" for a detailed description. Also see Net Results FORMULARY at **http://www.bcbsnc.com/netresults5tierC** . Please note: During a government issued public health EMERGENCY, the MEMBER expense may change for certain PRESCRIPTION DRUGS, reducing the out-of-pocket cost to the MEMBER. Find more information at **www.bluecrossnc.com/understanding-insurance/how-drug-benefits-work/copayment-tier-definitions.**		
Preventive over-the-counter medications and PRESCRIPTION contraceptive drugs and devices as listed at www.BlueCrossNC.com/preventive*	No Charge	No Charge**

Benefits	IN-NETWORK	OUT-OF-NETWORK
*Please visit the website at **www.BlueCrossNC.com/preventive** or call Blue Cross NC Customer Service for guidelines on which preventive over-the-counter medications are covered and individuals who may qualify, as well as more information and any limitations that apply for contraceptives. PRESCRIPTION contraceptive drugs and devices that are not covered at the PREVENTIVE CARE benefit level will be covered according to your regular PRESCRIPTION DRUG benefits. Also see "PREVENTIVE CARE" in "COVERED SERVICES." **No Charge indicates no obligation for MEMBERS to pay any portion of the ALLOWED AMOUNT. For OUT-OF-NETWORK benefits, you may be required to pay for charges over the ALLOWED AMOUNT, the difference between the ALLOWED AMOUNT and the billed charge.		

HOW BLUE OPTIONS WORKS

This section provides information about choosing services at the most cost-effective benefit level. It tells you about:

Table of Contents:	**Key Words:**
• Most Cost-Effective Benefit Level • OUT-OF-NETWORK Benefit Exceptions • Bundled Care and Payments Program • Carry your IDENTIFICATION CARD • Role of a PRIMARY CARE PROVIDER (PCP) or SPECIALIST	• PRIMARY CARE PROVIDER/SPECIALIST • ALLOWED AMOUNT vs. Billed Amount • Referrals • After-hours Care • Care Outside of North Carolina • PRIOR REVIEW • Filing Claims

Most Cost-Effective Benefit Level

As a MEMBER of the Blue Options plan, you enjoy quality health care from a network of health care PROVIDERS and easy access to SPECIALISTS. You do not have to get a referral to see your DOCTOR. You also have the freedom to choose health care PROVIDERS who do not participate in the Blue Options network – the main difference will be the cost to you. To get the most from your health care benefits, visit an IN-NETWORK PROVIDER.

Benefits are available for services from an IN- or OUT-OF-NETWORK PROVIDER that is recognized by Blue Cross NC as eligible. For a list of eligible PROVIDERS, please visit Blue Cross NC's website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service at the number listed in "Who to Contact?" Here's a look at how it works:

	IN-NETWORK	**OUT-OF-NETWORK**
Type of PROVIDER	IN-NETWORK PROVIDERS are health care professionals and facilities that have contracted with Blue Cross NC, or a PROVIDER participating in the BlueCard® program. ANCILLARY PROVIDERS outside North Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are provided, even if they participate in the BlueCard® program. See "Glossary" for a description of ANCILLARY	OUT-OF-NETWORK PROVIDERS are not designated as Blue Options PROVIDERS by Blue Cross NC. Also see "OUT-OF-NETWORK Benefit Exceptions."

	IN-NETWORK	OUT-OF-NETWORK
	PROVIDERS and the criteria for determining where services are received. The list of IN-NETWORK PROVIDERS may change from time to time. IN-NETWORK PROVIDERS are listed on Blue Cross NC's website at **www.BlueCrossNC.com**, or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"	
ALLOWED AMOUNT vs. Billed Amount	If the billed amount for COVERED SERVICES is greater than the ALLOWED AMOUNT, you are not responsible for the difference. You only pay any applicable copayment, deductible, coinsurance, and non-covered expenses. (See Filing Claims below for additional information.)	You may be responsible for paying any charges over the ALLOWED AMOUNT in addition to any applicable copayment, deductible, coinsurance, and non-covered expenses. For EMERGENCY SERVICES, see "OUT-OF-NETWORK Benefit Exceptions" and "EMERGENCY and Ambulance Services."
Referrals	Blue Cross NC does not require you to obtain any referrals.	
After-hours Care	If you need nonEMERGENCY services after your PROVIDER'S office has closed, please call your PROVIDER'S office for their recorded instructions.	
Care Outside of North Carolina	Your ID CARD gives you access to participating PROVIDERS outside the state of North Carolina through the BlueCard® program, and benefits are provided at the IN-NETWORK benefit level.	If you are in an area that has participating PROVIDERS and you choose a PROVIDER outside the network, you will receive the lower OUT-OF-NETWORK benefit. Also see "OUT-OF-NETWORK Benefit Exceptions."
PRIOR REVIEW	All IN-NETWORK PROVIDERS in North Carolina and some	OUT-OF-NETWORK PROVIDERS are not obligated by contract to

	outside of North Carolina are responsible for requesting PRIOR REVIEW when necessary. See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information about those services which require PRIOR REVIEW and CERTIFICATION. See "Who to Contact?" for information on who to call for PRIOR REVIEW and to obtain CERTIFICATION. PRIOR REVIEW is not required for EMERGENCY SERVICES or for an inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a Cesarean section.	request PRIOR REVIEW by Blue Cross NC. **You are responsible for ensuring that you or your OUT-OF-NETWORK PROVIDER requests PRIOR REVIEW by Blue Cross NC.** Failure to request PRIOR REVIEW and obtain CERTIFICATION will result in a full denial of benefits. However, PRIOR REVIEW is not required for EMERGENCY SERVICES or for an inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a Cesarean section.
Filing Claims	IN-NETWORK PROVIDERS in North Carolina are responsible for filing claims directly with Blue Cross NC. However, you will have to file a claim if you do not show your ID CARD when you obtain a PRESCRIPTION from an IN-NETWORK pharmacy, or the IN-NETWORK pharmacy's records do not show as eligible for coverage. In order to recover the full cost of the PRESCRIPTION minus any applicable copayment or coinsurance you owe, return to the IN-NETWORK pharmacy within 14 days of receiving your PRESCRIPTION so that it can be reprocessed with your correct eligibility information and the pharmacy will make a refund to you if necessary. If	You may have to pay the OUT-OF-NETWORK PROVIDER in full and submit your own claim to Blue Cross NC. Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER. For EMERGENCY SERVICES, see "OUT-OF-NETWORK Benefit Exceptions" and "EMERGENCY and Ambulance Services."

	you are unable to return to the pharmacy within 14 days, mail claims in time to be received within 18 months of the date of the service in order to receive IN-NETWORK benefits. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.	

OUT-OF-NETWORK Benefit Exceptions

You will only be responsible for your IN-NETWORK share of the cost and PROVIDERS may not bill you more than your IN-NETWORK share of the cost in the following situations:

- When EMERGENCY SERVICES are provided by an OUT-OF-NETWORK PROVIDER or an OUT-OF-NETWORK EMERGENCY facility*
- When you receive EMERGENCY MEDICALLY NECESSARY ground or air transport ambulance from an OUT-OF-NETWORK PROVIDER*
- When you receive MEDICALLY NECESSARY air transport ambulance from an OUT-OF-NETWORK PROVIDER*
- When non-EMERGENCY SERVICES are provided by an OUT-OF-NETWORK PROVIDER at an IN-NETWORK health care facility*
- When non-EMERGENCY SERVICES are provided by an OUT-OF-NETWORK PROVIDER in situations where IN-NETWORK PROVIDERS are not reasonably available as determined by Blue Cross NC's access to care standards
- In Continuity of Care situations

*These situations may not qualify for an OUT-OF-NETWORK PROVIDER benefit exception if the MEMBER gives consent. Please see **www.cms.gov/nosurprises** for notice regarding surprise billing describing your rights and how consent may impact these situations.

For more information, see one of the following sections: "EMERGENCY and Ambulance Services" in "COVERED SERVICES," or "Continuity of Care" in "UTILIZATION MANAGEMENT." For information about Blue Cross NC's access to care standards, visit Blue Cross NC's website at **www.BlueCrossNC.com** and type "access to care" in the search bar. If you believe an IN-NETWORK PROVIDER is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling Blue Cross NC before receiving care from an OUT-OF-NETWORK PROVIDER.

Bundled Care and Payments Program

Blue Cross NC is working with a select group of high-quality PROVIDERS to deliver coordinated care and simplified billing. All your care is coordinated for you, and all costs for services are billed together—saving time and reducing paperwork. Visit **www.BlueCrossNC.com/bundle** for more information and to see the list of PROVIDERS participating in this program. You will also want to verify that these PROVIDERS are in the Blue Options network by visiting **www.BlueCrossNC.com** or calling Blue Cross NC's Customer Service at the number listed in "Who to Contact?". The list of SURGERIES and specialties, and participating PROVIDERS under this program may change from time to time.

Carry Your IDENTIFICATION CARD

Your ID CARD identifies you as a Blue Options MEMBER. Be sure to carry your ID CARD with you at all times and present it each time you seek health care.

> For ID CARD requests, please visit Blue Cross NC's website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

The Role of a PRIMARY CARE PROVIDER (PCP) or SPECIALIST

Blue Cross NC is strongly committed to continuously improving your quality of care and reducing the cost of using health care services. Maintaining a relationship with a PCP, who will help you manage your health and make decisions about your health care needs is an important step towards ensuring you receive the highest quality of care. In certain situations you may be asked to select an available IN-NETWORK PCP after you enroll. While we are requesting you select a PCP it is not required. If you do choose a PCP you may change your selected PCP, including an OUT-OF-NETWORK PCP, at any time by visiting **www.BlueCrossNC.com**.

If you change PCPs, be sure to have your medical records transferred, especially immunization records, to provide your new PROVIDER with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care PROVIDER regardless of cost or benefit coverage. PCPs are trained to deal with a broad range of health care issues and can help you to determine when you need a SPECIALIST. PROVIDERS from medical specialties such as family practice, internal medicine, and pediatrics, may participate as PCPs.

Please visit Blue Cross NC's website at **www.BlueCrossNC.com** or call Blue Cross NC Customer Service to confirm that the PROVIDER is in the network before receiving care.

If your PCP or SPECIALIST leaves the Blue Cross NC PROVIDER network and they are currently treating you for an ongoing special condition, see "Continuity of Care" in "UTILIZATION MANAGEMENT."

Upon the request of the MEMBER and subject to approval by Blue Cross NC, a SPECIALIST treating a MEMBER for a serious or chronic disabling or life-threatening condition can act as the MEMBER'S PCP. The selected SPECIALIST would be responsible for providing and coordinating the MEMBER'S primary and specialty care. The selection of a SPECIALIST under these circumstances shall be made under a treatment plan approved by the SPECIALIST and Blue Cross NC, with notice to the PCP, if applicable. A request may be denied where it is determined that the SPECIALIST cannot appropriately coordinate the MEMBER'S primary and specialty care.

To make this request, or if you would like the professional qualifications of your PCP or IN-NETWORK SPECIALIST, you may call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

COVERED SERVICES

This section provides a more complete description of your benefits, along with some exceptions or services that are not covered by the PLAN. Keep in mind as you read this section Blue Options covers only those services that are MEDICALLY NECESSARY. Also check the "Summary of Benefits" for any benefit maximums and limitations that may apply to your benefits. We have grouped these COVERED SERVICES listed below to make it easier for you to find what you are looking for.

Table of Contents:

- Office Services
- PREVENTIVE CARE
- EMERGENCY and Ambulance Services
- URGENT CARE
- HOSPITAL and Other Facility Care
- Alternatives to HOSPITAL Stays
- Family Planning
- Specific Therapies and Tests
- Other Services
- Equipment and Supplies
- Surgical Benefits
- Mental Health/Substance Use Disorder Services
- PRESCRIPTION DRUG Benefits

Key Words:

- OFFICE VISIT
- OUTPATIENT CLINIC
- PREVENTIVE CARE
- IN-NETWORK
- OUT-OF-NETWORK
- REHABILITATIVE THERAPY /HABILITATIVE SERVICES
- ADAPTIVE BEHAVIOR TREATMENT
- GENERIC and BRAND-NAME PRESCRIPTION DRUGS

Office Services

The PLAN covers care you receive as part of an OFFICE VISIT, including:

- electronic visits
- evaluation and treatment of obesity
- house call
- telehealth services

Telehealth services from a local PROVIDER: You can check with your local PROVIDER to see if telehealth services are available. Telehealth services are available from IN-NETWORK and OUT-OF-NETWORK PROVIDERS. Telehealth services include, but are not limited to, evaluation, management, and consultative services for medical, counseling, and care management issues with a PROVIDER via an interactive audio/video or other telecommunication system. It is important to understand that your benefit will vary depending upon the type of PROVIDER you see for these services.

The PLAN also covers infusion services received at an AMBULATORY INFUSION SUITE. Certain infusion services may require PRIOR REVIEW and CERTIFICATION or services will not be covered.

If the PLAN has a copayment for PCP OFFICE VISITS, a copayment will not apply if you only receive services such as allergy shots or other injections and are not charged for an OFFICE VISIT.

Some DOCTORS or OTHER PROVIDERS may practice in HOSPITAL-based or OUTPATIENT CLINICS or provide HOSPITAL-based services in their offices. These services are covered as outpatient services and are listed as HOSPITAL-based or OUTPATIENT CLINIC. See "Summary of Benefits."

Some PROVIDERS may get ancillary services, such as laboratory services, medical equipment and supplies or PROVIDER-ADMINISTERED SPECIALTY DRUGS, from third parties. In these cases, you may be billed directly by the ANCILLARY PROVIDER. Benefit payments for these services will be based on the type of ANCILLARY PROVIDER, its network status, and how the services are billed.

> Please check with your PROVIDER before your visit to determine if your PROVIDER will collect deductible and coinsurance, or you can call Blue Cross NC Customer Service at the number listed in "Who to Contact?" for this information.

PREVENTIVE CARE

The PLAN covers PREVENTIVE CARE services that can help you stay safe and healthy.

Under federal law, you can receive certain covered PREVENTIVE CARE services from an IN-NETWORK PROVIDER in an office-based, outpatient, or ambulatory surgical setting, or URGENT CARE center, at no cost to you. Please note, this benefit is only for services that indicate a primary diagnosis of preventive or wellness and which are identified by recent federal regulations as being eligible. Services, such as diagnostic lab tests, that may be delivered with a PREVENTIVE CARE service are not considered PREVENTIVE CARE. These services and services that do not include a primary diagnosis of preventive or wellness will be subject to your IN-NETWORK benefit level for the location where services are received. In addition, if a particular PREVENTIVE CARE service does not have a federal recommendation or guideline concerning the frequency, method, treatment or setting in which it must be provided, the PLAN may use reasonable medical management procedures to determine any coverage limitations or restrictions that may apply.

Please visit Blue Cross NC's website at **www.BlueCrossNC.com/preventive** or call Blue Cross NC Customer Service at the number in "Who to Contact?" for the most up-to-date information on PREVENTIVE CARE that is covered under federal law, including any limitations that may apply. Certain over-the-counter medications may also be available. These over-the-counter medications are covered only as indicated and when a PROVIDER'S PRESCRIPTION is presented at a pharmacy.

Some services are only available IN-NETWORK as indicated below.

PREVENTIVE CARE COVERED SERVICES include:

Routine Physical Examinations and Screenings

Routine physical examinations and related diagnostic services and screenings are covered for MEMBERS as recommended with an A or B rating by the United States Preventive Services Task Force (USPSTF).

Well-Baby and Well-Child Care

These services are covered for each MEMBER including periodic assessments as recommended by the Health Resources and Services Administration (HRSA).

Well-Woman Care

These services are covered for each female MEMBER, including periodic assessments, screenings, counseling, or support services, as recommended by the Health Resources and Services Administration (HRSA).

Contraceptive Methods

Contraceptive methods and procedures requiring a PRESCRIPTION and approved by the U.S. Food and Drug Administration are covered for each female MEMBER with reproductive capacity. This includes intrauterine devices, diaphragms and caps, injectable or transdermal contraceptives, NuvaRing®, implanted hormonal contraceptives, certain EMERGENCY contraceptives and GENERIC oral contraceptives.

Immunizations

Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) are covered.

Nutritional Counseling

The plan provides benefits for nutritional counseling visits to an IN- or OUT-OF-NETWORK PROVIDER. The nutritional counseling visits may include counseling specific to achieving or maintaining a healthy weight. If you see an IN-NETWORK PROVIDER in an office-based setting, any applicable copayment or coinsurance or deductible is waived for these visits. If you go to an OUT-OF-NETWORK PROVIDER, deductible and coinsurance will apply. Additional visits may be covered for those MEMBERS diagnosed with diabetes; however, any applicable copayment, coinsurance or deductible will apply. Nutritional counseling visits are separate from the obesity-related OFFICE VISITS noted in "Summary of Benefits."

Tobacco Cessation

This PLAN provides benefits for some tobacco cessation over-the-counter nicotine replacement therapy (NRT) products, including patches, lozenges or gum, and FDA-approved PRESCRIPTION cessation medications.

Please log on to Blue Cross NC's website at **www.BlueCrossNC.com/preventive** or call Blue Cross NC Customer Service at the number listed in "Who to Contact?" for the most up-to-date information on tobacco cessation benefits.

The following benefits are available IN-NETWORK and OUT-OF-NETWORK.

Bone Mass Measurement Services

The PLAN covers one scientifically proven and approved bone mass measurement for the diagnosis and evaluation of osteoporosis or low bone mass during any 23-month period for certain qualified individuals only. Additional follow-up bone mass measurement tests will be covered if MEDICALLY NECESSARY. Please note that bone mass measurement tests will be covered under your diagnostic benefit (not your PREVENTIVE CARE benefit) if the claim for these services indicates a primary diagnosis of something other than preventive or wellness. Your diagnostic benefit will be subject to the benefit level for the location where services are received.

Qualified individuals include MEMBERS who have any one of the following conditions:

- Estrogen-deficient and at clinical risk of osteoporosis or low bone mass
- Radiographic osteopenia anywhere in the skeleton
- Receiving long-term glucocorticoid (steroid) therapy
- Primary hyperparathyroidism
- Being monitored to assess the response or effect of commonly accepted osteoporosis drug therapies
- History of low-trauma fractures
- Other conditions, or receiving medical therapies known to cause osteoporosis or low bone mass.

Colorectal Screening

Colorectal cancer examinations and laboratory tests for cancer are covered for any asymptomatic MEMBER who is at least 45 years of age, or is less than 45 years of age and at high risk for colorectal cancer. Increased/high-risk individuals are those who have a higher potential of developing colon cancer because of a personal or family history of certain intestinal disorders. Some of these procedures are considered SURGERY, such as colonoscopy and sigmoidoscopy, and others are considered lab tests, such as hemoccult screenings. Lab work done as a result of a colorectal screening exam will be covered under your diagnostic benefit and not be considered PREVENTIVE CARE. It will be subject to your benefit level for the location where services are received. However, lab work for the removal of polyps during the screening exam is considered PREVENTIVE CARE.

Gynecological Exam and Cervical Cancer Screening

The cervical cancer screening benefit includes the examination and laboratory tests for early detection and screening of cervical cancer, and a DOCTOR'S interpretation of the lab results. Coverage for cervical cancer screening includes Pap smear screening,

Benefit Booklet

For

for

BlueOptions®

An Independent Licensee of the Blue Cross and Blue Shield Association

L1338, 7/13

BENEFIT BOOKLET

This benefit booklet, along with the GROUP CONTRACT, is the legal contract between the GROUP and Blue Cross and Blue Shield of North Carolina. **Please read this benefit booklet carefully.**

Blue Cross and Blue Shield of North Carolina agrees to provide benefits to the qualified SUBSCRIBERS and eligible DEPENDENTS who are listed on the enrollment application and who are accepted in accordance with the provisions of the GROUP CONTRACT entered into between Blue Cross and Blue Shield of North Carolina and the SUBSCRIBER'S GROUP. A summary of benefits, conditions, limitations, and exclusions is set forth in this Benefit Booklet for easy reference.

Blue Cross and Blue Shield of North Carolina has directed that this Benefit Booklet be issued and signed by the President and the Secretary.

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA Incorporated 1968 North Carolina

Attest:

President

Secretary

Important Cancellation Information-Please Read The Provision In This Benefit Booklet Entitled, "When Coverage Begins And Ends."

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GETTING STARTED WITH STUDENT BLUE

IMPORTANT INFORMATION REGARDING THIS HEALTH BENEFIT PLAN: This health benefit plan includes coverage of a core set of benefits, called ESSENTIAL HEALTH BENEFITS, and certain limits on deductibles, copayments, and out-of-pocket costs. See "Glossary" for a list of the services that are considered ESSENTIAL HEALTH BENEFITS.

Note that while no annual or lifetime dollar limits are allowed on ESSENTIAL HEALTH BENEFITS, federal law does allow insurance companies to include annual or lifetime dollar limits on non-essential health benefits. This health benefit plan covers non-essential health benefits for routine adult eye exams, and adult lenses and frames. See "Summary of Benefits" for limits that apply.

In accordance with applicable federal law, Blue Cross and Blue Shield of North Carolina (Blue Cross NC) will not discriminate against any health care PROVIDER acting within the scope of their license or certification, or against any person who has received federal subsidies, or taken any other action to endorse his or her right under applicable federal law. Further, Blue Cross NC shall not impose eligibility rules or variations in premiums based on any specified health status-related factors unless specifically permitted by law.

Getting Started

This benefit booklet provides important information about your benefits and can help you understand how to maximize them. It's important that you read the entire booklet. If you need help or more information, it tells you how to contact us in the "Who to Contact?" section.

Notes on Words

As you read this benefit booklet, keep in mind that any word you see in small capital letters (SMALL CAPITAL LETTERS) is a defined term and appears in "Glossary" at the end of this benefit booklet. The terms "we," "us," and "Blue Cross NC" refer to Blue Cross and Blue Shield of North Carolina. The term "student health center (SHC)" refers to the student or campus health services at the school associated with this health benefit plan.

This Booklet

This booklet tells you about:

- Your COVERED SERVICES and exclusions or services that are not covered
- How your health benefit plan works
- How we share expenses for COVERED SERVICES

- Who is eligible to be covered under this health benefit plan and when this coverage starts and ends
- Our UTILIZATION MANAGEMENT programs and the right to appeal the decision
- Any Special Programs that may come with your health benefit plan.

PRIOR REVIEW and CERTIFICATION

Certain services require PRIOR REVIEW and CERTIFICATION in order for you to avoid a full denial of benefits. General categories of services requiring PRIOR REVIEW and CERTIFICATION are noted in "COVERED SERVICES." To determine if a specific service requires PRIOR REVIEW and CERTIFICATION, visit our website at **www.BlueCrossNC.com** for the PRIOR REVIEW list, which is updated when new services are added or when services are removed. You can also call Blue Cross NC Customer Service. See "PRIOR REVIEW/ Pre-Service" in "UTILIZATION MANAGEMENT" for information about the review process.

Exclusions and Limitations

Exclusions and limitations apply to your coverage. Service-specific exclusions are stated along with the benefit description in "COVERED SERVICES." Exclusions that apply to many services are listed in "What Is Not Covered?" To understand the exclusions and limitations that apply to each service, read "COVERED SERVICES," "Summary of Benefits" and "What Is Not Covered?"

No Assignment of Benefits

The benefits described in this benefit booklet are provided only for MEMBERS. These benefits, the right to receive payment under this health benefit plan, and the right to enforce any claim arising under this health benefit plan cannot be transferred or assigned to any other person or entity, including any PROVIDERS. Blue Cross NC will not recognize any such assignment, and any attempted assignment is void if performed without Blue Cross NC's prior written consent. Blue Cross NC may pay a PROVIDER directly. For example, Blue Cross NC pays IN-NETWORK PROVIDERS directly under applicable contracts with those PROVIDERS. However, any PROVIDER's right to be paid directly is through such contract with Blue Cross NC, and not through this health benefit plan. Under this health benefit plan, Blue Cross NC has the sole right to determine if payment for services is made to the PROVIDER, to the SUBSCRIBER, or allocated among both. Blue Cross NC's decision to pay a PROVIDER directly in no way reflects or creates any rights of the PROVIDER under this health benefit plan, including but not limited to benefits, payments, or procedures. For more information see "Additional Terms of Your Coverage."

More Information upon Request

You may receive, upon request, information about Student Blue, its services and DOCTORS, including printed copies of this benefit booklet with a benefit summary, and a directory of IN-NETWORK PROVIDERS.

Medical and Reimbursement Policies

Certain services are covered pursuant to Blue Cross NC medical and reimbursement policies, which are updated throughout the plan year. These policies describe the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is MEDICALLY NECESSARY and eligible for coverage, INVESTIGATIONAL or EXPERIMENTAL, COSMETIC, or a convenience item. The most up-to-date medical and reimbursement policies are available at **https://www.bluecrossnc.com/providers/medical-policies-and-coverage/search-medical-policy**, or call the number listed in "Who to Contact?"

Reduced or Waived Payments

- From time to time, MEMBERS may receive a reduced or waived copayment, deductible and/or coinsurance on designated services, therapies, or PRESCRIPTION DRUGS in connection with programs designed to reduce medical costs, or to encourage MEMBERS to seek appropriate, high quality, efficient care based on Blue Cross NC criteria.
- Depending on your plan, the manufacturer may, from time to time, provide a rebate, or discount for certain PRESCRIPTION DRUGS, or DURABLE MEDICAL EQUIPMENT. These rebates may be automatically applied to the ALLOWED AMOUNT of the PRESCRIPTION DRUG, or DURABLE MEDICAL EQUIPMENT, reducing the cost-sharing amounts you may owe. Which PRESCRIPTION DRUGS, or DURABLE MEDICAL EQUIPMENT receive rebates and how long the rebates are in place may change without notice.

Common Insurance Terms

To help you become familiar with some common insurance terms concerning what you may owe after visiting your PROVIDER, see the chart below and the "Glossary:"

Copayment	The fixed dollar amount you must pay for some COVERED SERVICES at the time you receive them, if this health benefit plan includes copayments. One copayment covers most services at a PROVIDER'S office. Copayments may also apply to URGENT CARE and emergency room services. Copayments are not credited to the BENEFIT PERIOD deductible; however, they are credited to the TOTAL OUT-OF-POCKET LIMIT.
Deductible	The dollar amount you must incur for COVERED SERVICES in a BENEFIT PERIOD before benefits are payable under this health benefit plan. The deductible does not include medical services received at SHC, inpatient newborn care for well-baby, coinsurance, charges in excess of the ALLOWED AMOUNT, amounts exceeding any maximum, or charges for non-COVERED SERVICES.

Coinsurance	The sharing of charges by Blue Cross NC and you for COVERED SERVICES, after you have met your BENEFIT PERIOD deductible. This is stated as a percentage of the ALLOWED AMOUNT. The coinsurance listed is your share of the cost of a COVERED SERVICE.
TOTAL OUT-OF-POCKET LIMIT	The TOTAL OUT-OF-POCKET LIMIT is the dollar amount you pay for COVERED SERVICES in a BENEFIT PERIOD before Blue Cross NC pays 100% of COVERED SERVICES. The TOTAL OUT-OF-POCKET LIMIT does not include charges over the ALLOWED AMOUNTS, premiums, and charges for noncovered services.

Here is an **example** of what your costs could be for IN-NETWORK or OUT-OF-NETWORK services. The scenario is a total outpatient HOSPITAL bill of $5,000.

	IN-NETWORK	OUT-OF-NETWORK
a) Total Bill	$5,000	$5,000
b) ALLOWED AMOUNT	$4,250	$4,250
c) Deductible Amount	**$250**	**$500**
d) ALLOWED AMOUNT Minus Deductible (B-C)	**$4,000**	**$3,750**
e) Your Coinsurance Amount (x% times D)	**(10%) $400**	**(30%) $1,125**
f) Amount You Owe Over ALLOWED AMOUNT	**$0** (IN-NETWORK charges limited to ALLOWED AMOUNT)	**$750** (difference between Total Bill and ALLOWED AMOUNT)
g) Total Amount You Owe (C+E+F)	**$650**	**$2,375**

Deductible and coinsurance amounts are for example only. See the "Summary of Benefits" for your benefits.

SPECIAL NOTICE IF YOU CHOOSE AN OUT-OF-NETWORK PROVIDER
Your actual expenses for COVERED SERVICES may exceed the stated coinsurance percentage or copayment amount because actual PROVIDER charges may not be used to determine the health benefit plan's and

MEMBER'S payment obligations. For OUT-OF-NETWORK benefits, you may be required to pay for charges over the ALLOWED AMOUNT, in addition to any copayment or coinsurance amount.

For Help in Reading this Benefit Booklet

Blue Cross NC provides consumer assistance tools and services for individuals living with disabilities (including accessible websites and the provision of auxiliary aids and services at no cost to the individual) in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act. Blue Cross NC also provides language services at no cost to the individual, including oral interpretation and written translations. To access these services and more, call 1-888-206-4697. For TTY and TDD, call 1-800-442-7028.

WHO TO CONTACT?

Toll-Free Phone Numbers, Website and Addresses

Blue Cross NC Customer Service: **1-888-234-2417**	For questions about your benefits, claims, premium payment, new IDENTIFICATION CARD (ID CARD) requests, or to voice a complaint.
	Use this secure MEMBER website to look at your plan, check benefits, eligibility, and claims status, download forms, manage your account, ask for new IDENTIFICATION CARDS, get helpful wellness information and more.
PRIOR REVIEW and CERTIFICATION: MEMBERS call: 1-888-234-2417 PROVIDERS call: 1-800-672-7897	Some services need PRIOR REVIEW and CERTIFICATION from Blue Cross NC. Up to date information about which services may need PRIOR REVIEW can be found online at **www.studentbluenc.com.**
PRESCRIPTION DRUG Information: **1-888-234-2417 and** **www.studentbluenc.com**	Call Blue Cross NC Customer Service or visit **www.studentbluenc.com** to access a list of IN-NETWORK pharmacies (including the Specialty Network); a list of PRESCRIPTION DRUGS that are subject to PRIOR REVIEW, quantity or benefit limitations; or a copy of the FORMULARY. You may also visit **www.BlueCrossNC.com/umdrug** for more information.
Behavioral Health: 1-800-359-2422 Counseling and Psychological Services: 919-660-1000	For questions about your mental health and substance use disorder benefits and claims. For mental health or substance use disorder services received in an office setting, you also have access to additional PROVIDERS. Call Counseling and Psychological Services for a list of these PROVIDERS.
Out of North Carolina Care: 1-800-810-BLUE (2583)	For help in obtaining care outside of North Carolina or the U.S., call this number or visit **www.bcbs.com.**
Health Line BlueSM: 1-877-477-2424	Talk to a nurse 24/7 to get timely information and help on a number of health-related issues. Nurses are on hand by phone in both English and Spanish.
Teladoc Telehealth: (800) 835-2362 and	For 24/7 access to a DOCTOR regarding non-EMERGENCY medical issues, call or visit the website to ask for a

https://www.teladoc.com	consultation. DOCTORS will be able to diagnose and suggest a treatment that's appropriate.
Nurse Support: 1-888-229-8510	Talk to a Nurse Advocate about receiving support for managing diabetes, respiratory conditions like asthma and chronic obstructive pulmonary disease (COPD), cardiovascular conditions like congestive heart failure, coronary artery disease (CAD), or hypertension and other conditions. Please talk to your GROUP ADMINISTRATOR to see if this program is available to you.
My Pregnancy: **www.BCBSNC.com/mypregnancy**	For information about programs and support for managing your pregnancy. Please talk to your GROUP ADMINISTRATOR to see if this program is available to you.
Medical Claims Filing: Blue Cross NC Claims Department PO Box 35 Durham, NC 27702-0035	Mail completed medical and pediatric dental or vision claims, including international claim forms, to this address.
PRESCRIPTION DRUG Claims Filing: Prime Therapeutics Mail Route: Commercial Blue Cross NC PO Box 25136 Lehigh Valley, PA 18002-5136	Mail completed PRESCRIPTION DRUG claims to this address.

Value-Added Programs

Please note: These programs are not covered benefits and are outside of this health benefit plan. Blue Cross NC does not accept claims or reimburse for these goods or services, and MEMBERS are responsible for paying all bills. Blue Cross NC may change or discontinue these programs at any time.

Blue365™

Keep your body – and budget – healthy

Staying healthy and active should be easy – and affordable. That's why Blue Cross NC offers Blue365™. It's a simple way to save on everything you need for a well-balanced lifestyle.

Get deals, discounts & more:

WHO TO CONTACT? *(cont.)*

- Fitness: Gym memberships & fitness gear
- Personal Care: Vision & hearing care
- Healthy Eating: Weight loss & nutrition programs
- Lifestyle: Travel & family activities
- Wellness: Mind/body wellness tools & resources
- Financial Health: Financial tools & programs

Join and save

Visit **www.BlueCrossNC.com/blue365**

Or call 1-855-511-BLUE (2583)

SUMMARY OF BENEFITS

This section provides a summary of your Student Blue benefits. A more complete description of your benefits is found in "COVERED SERVICES." General exclusions may also apply—please see "What Is Not Covered?" As you review the "Summary of Benefits" chart, keep in mind:

- Multiple OFFICE VISITS or emergency room visits on the same day may result in multiple copayments
- Coinsurance percentages shown in this section are the part of the ALLOWED AMOUNT that you pay for COVERED SERVICES
- Amounts applied to any deductible and coinsurance are based on the ALLOWED AMOUNT
- Amounts applied to any deductible also count toward any visit or day maximums for those services
- Benefits may differ depending on where the service is performed and if the service is received with any other service or associated with a surgical procedure

Please Note: The list of IN-NETWORK PROVIDERS may change from time to time, so please verify that the PROVIDER is still in the Blue Options network before receiving care. Find a PROVIDER on the website at **studentbluenc.com** or call the number listed on your ID CARD or in "Who to Contact?"

BENEFIT PERIOD—08/01/2023 through 07/31/2024

Benefit payments are based on where services are received and how services are billed.

Benefits	IN-NETWORK	OUT-OF-NETWORK
Deductibles, TOTAL OUT-OF-POCKET LIMITS, and Benefit Maximums The following deductible, limits and maximums apply to the services listed below in the "Summary of Benefits" unless otherwise noted.		
Deductible		
Individual, per BENEFIT PERIOD	$0	$250
Family, per BENEFIT PERIOD	$0	$750
Charges for the following do not apply to the BENEFIT PERIOD deductible: • Medical services received at SHC • Inpatient newborn care for well-baby • PRESCRIPTION DRUGS This health benefit plan has an embedded deductible which means you have an individual deductible and if DEPENDENTS are covered, you also have a combined family deductible. You must meet your individual deductible before benefits are payable under this health benefit plan. However, once the family deductible is met, it is met for all covered family members. IN-NETWORK services are credited to your IN-NETWORK deductible and OUT-OF-NETWORK services are credited to your OUT-OF-NETWORK deductible.		
TOTAL OUT-OF-POCKET LIMIT		
Individual, per BENEFIT PERIOD	$2,000	$3,000
Family, per BENEFIT PERIOD	$4,500	$9,000
Charges over ALLOWED AMOUNTS, premiums, and charges for non-covered services do not apply to the TOTAL OUT-OF-POCKET LIMIT. This health benefit plan has an embedded individual TOTAL OUT-OF-POCKET LIMIT, which means you have an individual TOTAL OUT-OF-POCKET LIMIT and if DEPENDENTS are covered, you also have a combined family TOTAL OUT-OF-POCKET LIMIT. Once a MEMBER meets their individual TOTAL OUT-OF-POCKET LIMIT the health benefit plan will pay 100% of the ALLOWED		

Benefits	IN-NETWORK	OUT-OF-NETWORK
AMOUNT for COVERED SERVICES for that individual. Once the family TOTAL OUT-OF-POCKET LIMIT is met, it is met for all MEMBERS. Charges for IN-NETWORK services apply to your IN-NETWORK TOTAL OUT-OF-POCKET LIMIT and charges for OUT-OF-NETWORK services apply to your OUT-OF-NETWORK TOTAL OUT-OF-POCKET LIMIT.		
LIFETIME MAXIMUMS Per MEMBER	Unlimited	
Unlimited for all services unless otherwise noted below. Maximums are per MEMBER per lifetime and combined IN- and OUT-OF-NETWORK, unless noted otherwise. If you exceed any LIFETIME MAXIMUM, additional services of that type are not covered. In this case, you may be responsible for the entire amount of the PROVIDER's billed charge.		
INFERTILITY PRESCRIPTION DRUGS	Quantity limits apply, see **www.BlueCrossNC.com/umdrug** PRESCRIPTION DRUGS indicated to treat INFERTILITY will be included in this benefit limit as they are approved by the U.S. Food and Drug Administration (FDA).	
INFERTILITY Services	Three ovulation induction cycles, with or without insemination, per MEMBER for INFERTILITY services, provided in all places of service.	
Medical Evacuation and Repatriation of Mortal Remains	Unlimited	
Orthotic Devices for POSITIONAL PLAGIOCEPHALY	One device (includes dynamic orthotic cranioplasty (DOC) bands and soft helmets)	
Vein Treatment	Endovenous or microfoam-sclerotherapy procedures—one procedure per limb Liquid sclerotherapy tributary vein treatment—three procedures per limb	
BENEFIT PERIOD MAXIMUMS Per MEMBER		
Maximums are per BENEFIT PERIOD and combined IN- and OUT-OF-NETWORK, unless noted otherwise. Any services in excess of these benefit maximums are not COVERED SERVICES. All day and visit limits are for IN- and OUT-OF-NETWORK benefits combined.		
Breast Pump and Supplies	Limit of one (1) manual or electric pump. Limit of two (2) each for supplies including but not limited to, tubing,	

Benefits	IN-NETWORK	OUT-OF-NETWORK
	shields and bottles. See **www.bluecrossnc.com/preventive** for more information.	
Dialysis Treatment	Three hemodialysis treatments per week, more hemodialysis treatments are available if MEDICALLY NECESSARY	
Evaluation and Treatment of Obesity	Four visits, applies to office and outpatient setting. These visits are separate from any nutritional counseling visits.	
Nutritional Counseling	30 visits Visit limits do not apply to MENTAL ILLNESS diagnoses.	
Hearing Aids	One hearing aid per hearing-impaired ear every 36 months.	
Pediatric Vision Services	One routine comprehensive eye examination. Either one pair of eyeglass lenses and frames or one pair of contact lenses in place of eyeglasses and certain low vision aids such as magnifiers. One comprehensive low vision examination every five years and four follow-up visits in any five-year period.	
Adult Lenses And Frames	$100 This benefit is a non-essential health benefit and is available for MEMBERS age 19 and older. For MEMBERS up to age 19, see "Pediatric Vision" for your lenses and frames benefit. Blue Cross NC will reimburse you up to the BENEFIT PERIOD MAXIMUM for prescribed eyeglasses and hard, soft or disposable contact lenses. Any services in excess of this BENEFIT PERIOD MAXIMUM are not COVERED SERVICES.	
REHABILITATIVE THERAPIES **HABILITATIVE SERVICES** (REHABILITATIVE THERAPIES and HABILITATIVE SERVICES have separate limits. Benefit	50 visits for physical/occupational therapy/ chiropractic services and 30 visits for speech therapy. 50 visits for physical/occupational therapy/ chiropractic services and 30 visits for speech therapy. Visit limits do not apply to MENTAL ILLNESS diagnoses.	

Benefits	IN-NETWORK	OUT-OF-NETWORK
applies to home, office, and outpatient setting)		
SKILLED NURSING FACILITY	Unlimited	
Provider's Office		
For IN-NETWORK medical services provided in the office, you pay only a copayment. For all other services provided in the office, see "Other Office Services" below.		
See "Outpatient Services" for OUTPATIENT CLINIC or HOSPITAL-based services.		
OFFICE VISITS		
Student Health Center (SHC)	No Charge	**Benefits not available**
Other PRIMARY CARE PROVIDER (PCP)	$25 copayment	30% after deductible
Other SPECIALIST	$35 copayment	30% after deductible
Teladoc Telehealth	$10 copayment	Not Applicable
Telehealth services are also available from a local IN-NETWORK or OUT-OF-NETWORK PROVIDER; see "Office Services" in "COVERED SERVICES."		
Copayment only applies to charge for the office visit. Also included are infusion services received at an AMBULATORY INFUSION SUITE. If you see your PCP for mental health or substance use disorder related services, these services are included as well.		
Other Office Services	20%	30% after deductible
Includes office surgery, x-rays and lab tests.		
PREVENTIVE CARE Services		
This benefit is only for services that your PROVIDER indicates a primary diagnosis of preventive or wellness on the claim that is submitted to Blue Cross NC. Also see "PREVENTIVE CARE" in "COVERED SERVICES." For PREVENTIVE CARE services that are not mandated by federal or state law, benefits will depend on where the services are received.		
Federally-mandated PREVENTIVE CARE	No Charge	30% after deductible
For the most up-to-date list of PREVENTIVE CARE services that are covered under federal law, including PRESCRIPTION contraceptives and certain preventive over-the-counter medications, general preventive services and screenings, immunizations,		

Benefits	IN-NETWORK	OUT-OF-NETWORK
well-baby/well-child care, and women's PREVENTIVE CARE, see the website at **www.bluecrossnc.com/preventive** or call the number in "Who to Contact?" Routine eye exams are only covered IN-NETWORK as non-mandated PREVENTIVE CARE. Nutritional counseling visits are covered regardless of diagnosis.		
State-mandated PREVENTIVE CARE	No Charge	30% after deductible
The following services are state-mandated and required to be offered both IN- and OUT-OF-NETWORK: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.		
REHABILITATIVE THERAPY and HABILITATIVE Services		
PRIMARY CARE PROVIDER	$25 copayment	30% after deductible
SPECIALIST	20%	30% after deductible
Combined IN- and OUT-OF-NETWORK BENEFIT PERIOD MAXIMUMS apply to home, office and outpatient settings.		
OTHER THERAPIES	20%	30% after deductible
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See "Therapies" for OTHER THERAPIES provided in an outpatient setting.		
Pediatric DENTAL SERVICES		
Preventive and Diagnostic Services	No Charge	30% after deductible
Basic and Major Services	20% after deductible	30% after deductible
Orthodontic Services (if CLINICALLY NECESSARY)	20% after deductible	30% after deductible
The benefits listed above are only available for MEMBERS up to the end of the month they become age 19. See "Pediatric DENTAL SERVICES" in "COVERED SERVICES" for a description of the available benefits.		
Pediatric Vision Services		
Lenses and/or Contact Lenses	50% after deductible	
Frames	50% after deductible	

Benefits	IN-NETWORK	OUT-OF-NETWORK
The benefits listed above are only available for MEMBERS up to the end of the month they become age 19. See "Pediatric Vision Services" in "COVERED SERVICES" for a description of these benefits. See "PREVENTIVE CARE" for routine eye examination, which is also covered.		
INFERTILITY Services		
PRIMARY CARE PROVIDER	$25 copayment	30% after deductible
SPECIALIST	$35 copayment	30% after deductible
Copayment only applies to charge for the office visit.		
Other Office Services	20%	30% after deductible
Obesity Treatment/Weight Management		
PRIMARY CARE PROVIDER	$25 copayment	30% after deductible
SPECIALIST	$35 copayment	30% after deductible
Other Office Services	20%	30% after deductible
Outpatient Services	20%	30% after deductible
Inpatient Physician Services	20%	30% after deductible
Inpatient HOSPITAL and HOSPITAL-based Services	20%	30% after deductible
Copayment only applies to charge for the office visit.		
URGENT CARE Centers		
PRIMARY CARE PROVIDER OR SPECIALIST visit	$45 copayment	$90 copayment
OTHER SERVICES	20%	30% after deductible
EMERGENCY and Ambulance Services		
Ambulance	20%	20%
EMERGENCY SERVICES	$150 copayment, then 20%	$150 copayment, then 20%
See "COVERED SERVICES" for more information regarding coverage of EMERGENCY and air ambulance services. If you are sent to the emergency room from an URGENT CARE center,		

Benefits	IN-NETWORK	OUT-OF-NETWORK
you may be responsible for both the emergency room copayment and the URGENT CARE copayment.		
Outpatient Services		
Outpatient Services	20%	30% after deductible
HOSPITAL-based or OUTPATIENT CLINIC Services		
PRIMARY CARE PROVIDER	$25 copayment	30% after deductible
SPECIALIST	$35 copayment	30% after deductible
Other Services	20%	30% after deductible
Outpatient Diagnostic Services		
Outpatient lab tests, when performed alone or with another service (physician and HOSPITAL-based services)	20% after deductible	30% after deductible
Outpatient diagnostic mammography (physician and HOSPITAL-based services)	No Charge	30% after deductible
See "PREVENTIVE CARE" for coverage of screening mammograms.		
Inpatient Services		
Physician Services	20%	30% after deductible
HOSPITAL and HOSPITAL-based Services	20%	30% after deductible
Includes maternity delivery, prenatal, and post-delivery care. If you are in a HOSPITAL as an inpatient at the time you begin a new BENEFIT PERIOD, you may have to meet a new deductible for COVERED SERVICES from DOCTORS or OTHER PROFESSIONAL PROVIDERS.		
Additional COVERED SERVICES		
	20%	30% after deductible
Includes DURABLE MEDICAL EQUIPMENT, HOSPICE services, MEDICAL SUPPLIES, orthotic devices, private duty nursing, PROSTHETIC APPLIANCES, AMBULATORY SURGICAL CENTER,		

Benefits	IN-NETWORK	OUT-OF-NETWORK
SKILLED NURSING FACILITY, outpatient x-rays, ultrasounds, diagnostic tests (EEGs, EKGs and pulmonary function tests) and scans (CT scans, MRIs, MRAs, and PET scans), and home health care.		
Mental Health And Substance Use Disorder Services		
Mental Health/Substance Use Disorder Office Services	$10 copayment	30% after deductible
Mental Health/Substance Use Disorder Inpatient and RESIDENTIAL TREATMENT FACILITY Services		
Physician Services	20%	30% after deductible
HOSPITAL and HOSPITAL-based Services	20%	30% after deductible
Mental Health/Substance Use Disorder Outpatient Services	20%	30% after deductible
CERTIFICATION Requirements		
Certain services require PRIOR REVIEW and CERTIFICATION in order to receive benefits. IN-NETWORK PROVIDERS in North Carolina will request PRIOR REVIEW when necessary. IN-NETWORK inpatient FACILITIES outside of North Carolina will also request PRIOR REVIEW for you, except for Veterans Affairs (VA) and military providers. Otherwise, if you go to an OUT-OF-NETWORK PROVIDER in North Carolina or to any other PROVIDER outside of North Carolina, you are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by Blue Cross NC. **Failure to request PRIOR REVIEW and receive CERTIFICATION will result in full denial of benefits.** See "COVERED SERVICES" and "PRIOR REVIEW (Pre-Service)" in "UTILIZATION MANAGEMENT" for additional information. Blue Cross NC delegates PRIOR REVIEW and CERTIFICATION for particular benefits to other companies not associated with Blue Cross NC. Please see **https://www.BlueCrossNC.com/content/services/medical-policy/index.htm** for a detailed list of these companies and benefits. While some benefits have been identified under "COVERED SERVICES," the list of benefits and/or companies may change from time to time; for the most up-to-date information visit **https://www.BlueCrossNC.com/content/services/medical-policy/index.htm.** To request PRIOR REVIEW, please see the numbers in "Who to Contact?"		

PRESCRIPTION DRUGS		
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 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. See Essential Q FORMULARY at **http://www.bcbsnc.com/essentialQ**. 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 PROVIDER required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts may still apply.		
TIER 1 DRUGS	$4 copayment	$4 copayment
TIER 2 DRUGS	$15 copayment	$15 copayment
TIER 3 DRUGS	$35 copayment	$35 copayment
TIER 4 DRUGS	$60 copayment	$60 copayment
TIER 5 DRUGS	25%	25%
TIER 6 DRUGS	25%	25%
Diabetic Supplies, Spacers and Peak Flow Meters	$10 copayment	$10 copayment
Please note: your benefit plan uses the QHP Essential FORMULARY and has a 6 TIER pharmacy benefit. One copayment for up to a 30-day supply. 31-60-day supply is two copayments, and 61-90-day supply is three copayments. For each 30-day supply of a TIER 5 or TIER 6 DRUG you will pay a minimum of $100 in coinsurance, but not more than coinsurance up to $200. Any OUT-OF-NETWORK charges over the ALLOWED AMOUNT are not included in this maximum. Limits apply to INFERTILITY drugs, see "PRESCRIPTION DRUG Benefits" in "COVERED SERVICES" for a detailed description. Any services in excess of this LIFETIME MAXIMUM are not COVERED SERVICES. Visit Blue Cross NC's website at **BlueCrossNC.com** to find out the tier classifications of your PRESCRIPTION DRUGS. Also see Essential Q FORMULARY at **http://www.bcbsnc.com/essentialQ**. Please note: During a government issued public health emergency, the MEMBER expense may change for certain PRESCRIPTION DRUGS, reducing the out-of-pocket cost to the		

Benefits	IN-NETWORK	OUT-OF-NETWORK
MEMBER. Find more information at **https://www.bluecrossnc.com/understanding-insurance/how-drug-benefits-work/copayment-tier-definitions.**		
Preventive over-the-counter medications and PRESCRIPTION contraceptive drugs and devices as listed at www.BlueCrossNC.com/preventive*	No Charge	No Charge**
*Please visit the website at **www.BlueCrossNC.com/preventive** or call the number in "Who to Contact?" for guidelines on which preventive over-the-counter medications are covered and individuals who may qualify, as well as more information and any limitations that apply for contraceptives. PRESCRIPTION contraceptive drugs and devices that are not covered at the PREVENTIVE CARE benefit level will be covered according to your regular PRESCRIPTION DRUG benefits. Also see "PREVENTIVE CARE" in "COVERED SERVICES." **No Charge indicates no obligation for MEMBERS to pay any portion of the ALLOWED AMOUNT. For OUT-OF-NETWORK benefits, you may be required to pay any difference between the ALLOWED AMOUNT and the billed charge.		

HOW STUDENT BLUE WORKS

This section provides information about choosing services at the most cost-effective benefit level. It tells you about:

Table of Contents:	**Key Words:**
• Most Cost-Effective Benefit Level • Student Health Center (SHC) • OUT-OF-NETWORK Benefit Exceptions • Bundled Care and Payments Program • Carry your ID CARD • Role of a PRIMARY CARE PROVIDER (PCP) or SPECIALIST • Premium Payments	• PRIMARY CARE PROVIDER/SPECIALIST • ALLOWED AMOUNT vs. Billed Amount • Referrals • After-hours Care • Care Outside of North Carolina • PRIOR REVIEW • Filing Claims

Most Cost-Effective Benefit Level

As a MEMBER of the Student Blue plan, you will enjoy quality health care from a network of health care PROVIDERS and easy access to SPECIALISTS. You also have the freedom to choose health care PROVIDERS who do not participate in the Blue Options network – the main difference will be the cost to you. Benefits are available for services received from an IN- or OUT-OF-NETWORK PROVIDER that is recognized by Blue Cross NC as eligible. For a list of eligible PROVIDERS, please visit our website at **www.studentbluenc.com** or call Blue Cross NC Customer Service at the number listed in "Who to Contact?"

Student Health Center (SHC)

The student health center (SHC) at your school provides access to medical care for all students who have paid the student health fee. In order to make the most of your benefits, visit SHC first. If the services you receive at SHC are not covered by the student health fee, you may need to complete a claim form and file with Blue Cross NC. You may also be responsible for requesting PRIOR REVIEW and receiving CERTIFICATION from Blue Cross NC when necessary. See "How to File a Claim" and "Prior Review/Pre-Service." If you require services of a DOCTOR outside SHC, they can guide you to the appropriate PROVIDER.

	In-Network	**Out-of-Network**
Type of PROVIDER	IN-NETWORK PROVIDERS are health care professionals and facilities that have contracted with Blue Cross NC, or a PROVIDER participating in the BlueCard® program. ANCILLARY PROVIDERS outside North	OUT-OF-NETWORK PROVIDERS are not designated as a PPO PROVIDER by Blue Cross NC. Also see "OUT-OF-NETWORK Benefit Exceptions."

	In-Network	Out-of-Network
	Carolina are considered IN-NETWORK only if they contract directly with the Blue Cross or Blue Shield plan in the state where services are received, even if they participate in the BlueCard® program. See the "Glossary" for a description of ANCILLARY PROVIDERS and the criteria for determining where services are received. IN-NETWORK PROVIDERS agree to limit charges for COVERED SERVICES to the ALLOWED AMOUNT. The list of IN-NETWORK PROVIDERS may change from time to time. IN-NETWORK PROVIDERS are listed at **www.studentbluenc.com**, or call the number listed in "Who to Contact?"	
ALLOWED AMOUNT vs. Billed Amount	If the billed amount for COVERED SERVICES is greater than the ALLOWED AMOUNT, you are not responsible for the difference. You only pay any applicable copayment, deductible, coinsurance, and non-covered expenses. (See "Filing Claims" below for additional information.)	You may be responsible for paying any charges over the ALLOWED AMOUNT in addition to any applicable deductible, coinsurance, and non-covered expenses. For EMERGENCY SERVICES, see "OUT-OF-NETWORK Benefit Exceptions" and "EMERGENCY and Ambulance Services" for additional information.
Referrals	Blue Cross NC does not require you to obtain any referrals.	

After-hours Care	If you need non-EMERGENCY services after your PROVIDER'S office has closed, please call your PROVIDER'S office for their recorded instructions. You may also contact the nurse advice line, Health Line Blue, for assistance.	
Care Outside of North Carolina	Your ID CARD gives you access to participating PROVIDERS outside the state of North Carolina through the BlueCard® Program, and benefits are provided at the IN-NETWORK benefit level.	If you are in an area that has participating PROVIDERS and you choose a PROVIDER outside the network, you will receive the lower OUT-OF-NETWORK benefit. Also see "OUT-OF-NETWORK Benefit Exceptions."
PRIOR REVIEW	IN-NETWORK PROVIDERS in North Carolina are responsible for requesting PRIOR REVIEW when necessary. IN-NETWORK PROVIDERS outside of North Carolina, except for Veterans' Affairs (VA) and military PROVIDERS, are responsible for requesting PRIOR REVIEW for inpatient FACILITY SERVICES. For all other COVERED SERVICES received outside of North Carolina, **you** are responsible for ensuring that you or your PROVIDER requests PRIOR REVIEW by Blue Cross NC or its designee even if you see an IN-NETWORK PROVIDER. See "Who to Contact?" for information on who to call for PRIOR REVIEW and to obtain CERTIFICATION for mental health and substance use disorder services and all other medical services. PRIOR REVIEW is not required for EMERGENCY SERVICES or for an	OUT-OF-NETWORK PROVIDERS are not obligated by contract to request PRIOR REVIEW by Blue Cross NC. **You are responsible for ensuring that you or your OUT-OF-NETWORK PROVIDER in or outside of North Carolina, requests PRIOR REVIEW by Blue Cross NC or its designee when necessary.** See "Who to Contact?" for information on who to call for PRIOR REVIEW and to obtain CERTIFICATION for mental health and substance use disorder services and all other medical services. Failure to request PRIOR REVIEW and obtain CERTIFICATION will result in a full denial of benefits. However, PRIOR REVIEW is not required for EMERGENCY SERVICES or for an inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a Cesarean section.

	inpatient HOSPITAL stay for 48 hours after a vaginal delivery or 96 hours after a Cesarean section.	
Filing Claims	IN-NETWORK PROVIDERS in North Carolina are responsible for filing claims directly with Blue Cross NC. However, you will have to file a claim if you do not show your ID CARD when you obtain a PRESCRIPTION from an IN-NETWORK pharmacy, or the IN-NETWORK pharmacy's records do not show as eligible for coverage. In order to recover the full cost of the PRESCRIPTION minus any applicable copayment or coinsurance you owe, you will need to return to the IN-NETWORK pharmacy within 14 days of receiving your PRESCRIPTION so that it can be reprocessed with your correct eligibility information and the pharmacy will make a refund to you, if necessary. If you are unable to return to the pharmacy within 14 days, mail claims in time to be received within 18 months of the date of the service in order to receive IN-NETWORK benefits. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER.	You may have to pay the OUT-OF-NETWORK PROVIDER in full and submit your own claim to Blue Cross NC. Mail claims in time to be received within 18 months of the date the service was provided. Claims not received within 18 months from the service date will not be covered, except in the absence of legal capacity of the MEMBER. For EMERGENCY SERVICES, see "OUT-OF-NETWORK Benefit Exceptions" and "EMERGENCY and Ambulance Services."

OUT-OF-NETWORK Benefit Exceptions

You will only be responsible for your IN-NETWORK share of the cost and PROVIDERS may not bill you more than your IN-NETWORK share of the cost in the following situations:

- When EMERGENCY SERVICES are provided by an OUT-OF-NETWORK PROVIDER or an OUT-OF-NETWORK EMERGENCY facility*
- When you receive EMERGENCY MEDICALLY NECESSARY ground or air transport ambulance from an OUT-OF-NETWORK PROVIDER*
- When you receive MEDICALLY NECESSARY air transport ambulance from an OUT-OF-NETWORK PROVIDER*
- When non-EMERGENCY SERVICES are provided by an OUT-OF-NETWORK PROVIDER at an IN-NETWORK health care facility*
- When non-EMERGENCY SERVICES are provided by an OUT-OF-NETWORK PROVIDER in situations where IN-NETWORK PROVIDERS are not reasonably available as determined by Blue Cross NC's access to care standards
- In continuity of care situations

  *These situations may not qualify for an OUT-OF-NETWORK benefit exception if the MEMBER gives consent. Please see **https://www.cms.gov/nosurprises** for notice regarding surprise billing describing your rights and how consent may impact these situations.

For more information, see one of the following sections: "EMERGENCY and Ambulance Services" in "COVERED SERVICES" or "Continuity of Care" in "UTILIZATION MANAGEMENT." For information about Blue Cross NC's access to care standards, see the website at **www.BlueCrossNC.com** and type "access to care" in the search bar. If you believe an IN-NETWORK PROVIDER is not reasonably available, you can help assure that benefits are paid at the correct benefit level by calling Blue Cross NC before receiving care from an OUT-OF-NETWORK PROVIDER.

Bundled Care and Payments Program

Blue Cross NC is working with a select group of high-quality PROVIDERS to deliver coordinated care and simplified billing. All your care is coordinated for you, and all costs for services are billed together—saving time and reducing paperwork. Visit **www.BlueCrossNC.com/bundle** for more information and to see the list of PROVIDERS participating in this program. You'll also want to verify that these PROVIDERS are in the Blue Options network by visiting **www.BlueCrossNC.com** or calling Blue Cross NC Customer Service at the number listed in "Who to Contact?" The list of SURGERIES and specialties, and participating PROVIDERS under this program may change from time to time.

Carry Your ID CARD

Your ID CARD identifies you as a Blue Options MEMBER. Be sure to carry your ID CARD with you at all times and present it each time you seek health care.

For ID CARD requests, please visit the website at Student Blue SM or call the number listed in "Who to Contact?"

The Role of a PRIMARY CARE PROVIDER (PCP) or SPECIALIST

Blue Cross NC does not require that you designate a PCP to manage your health care. However, it is important for you to maintain a relationship with a PCP, either at SHC or outside of SHC, who will help you manage your health and make decisions about your health care needs. If you change PCPs, be sure to have your medical records transferred, especially immunization records, to provide your new DOCTOR with your medical history. You should participate actively in all decisions related to your health care and discuss all treatment options with your health care PROVIDER regardless of cost or benefit coverage. PCPs are trained to deal with a broad range of health care issues and can help you to determine when you need a SPECIALIST. PROVIDERS from medical specialties such as family practice, internal medicine and pediatrics may participate as PCPs.

Please visit our website at Student Blue SM and click on Find a Doctor, or call the number listed in "Who to Contact?" to confirm that the PROVIDER is in the network before receiving care.

If your PCP or SPECIALIST leaves our PROVIDER network and they are currently treating you for an ongoing special condition, see "Continuity of Care" in "UTILIZATION MANAGEMENT."

Upon the request of the MEMBER and subject to approval by Blue Cross NC, a SPECIALIST treating a MEMBER for a serious or chronic disabling or life-threatening condition can act as the MEMBER'S PCP. The selected SPECIALIST would be responsible for providing and coordinating the MEMBER'S primary and specialty care. The selection of a SPECIALIST under these circumstances shall be made under a treatment plan approved by the SPECIALIST and Blue Cross NC, with notice to the PCP if applicable. A request may be denied where it is determined that the SPECIALIST cannot appropriately coordinate the MEMBER'S primary and specialty care.

To make this request or if you would like the professional qualifications of your PCP or IN-NETWORK SPECIALIST, you may call Blue Cross NC at the number listed in "Who to Contact?"

Premium Payment

If premium payments are the responsibility of the SUBSCRIBER and are not received by Blue Cross NC on or before the premium due date, the MEMBER'S coverage will automatically terminate as of the paid through date. If you pay premiums through automatic bank draft and there are insufficient funds, Blue Cross NC may attempt to debit your bank account until sufficient funds are received. We will not make more than three attempts to debit your bank account. Blue Cross NC may charge a fee for this service. Your bank may also charge a fee if

there are insufficient funds to cover the payment. Requests to discontinue bank draft must be received, in writing, at least 10 days prior to the scheduled draft. For any questions concerning premium payment, please contact the number listed in "Who to Contact?"

If premium payments are not made within the time allowed, this health benefit plan will be terminated. In order to enroll in a new plan after terminating for nonpayment, Blue Cross NC may require you to pay any past due premiums within the last 12 months in addition to the first month's premium for your new plan, as allowed under federal law.

Grace Period

If premium payment is not received by the due date you will receive a grace period to allow time for payment before your policy terminates.

- A 30-day grace period applies to your health benefit plan

Reinstating Your Policy

If your health benefit plan has been terminated for nonpayment and you wish that it be reinstated, the following applies:

- You must request reinstatement within 30 days from the date of the termination notice using one of the following options:
  - Submit a written request along with a certified check payable to Blue Cross NC

    Mail to: Blue Cross NC
    Financial Processing Services
    Student Blue
    PO Box 2073
    Durham, NC 27702
  - Call our pay-by-phone number at 1-800-333-7009 to pay with credit or debit card or have your checking account drafted
- To be reinstated, you must pay any overdue premiums owed plus the current amount due, and any administrative fees in order to bring your account to a current status.

In the event that reinstatement is not approved, you may choose to reapply for health insurance coverage at the allowed times by filling out the proper application. Reapplying for coverage does not guarantee approval of coverage.

Please note that premium payments are automatically deposited. Blue Cross NC's deposit of premiums does not mean an acceptance of coverage. If you have been notified that your coverage is terminated or is scheduled to be terminated, any deposit of premiums by Blue Cross NC in excess of premiums that are due and owing for the coverage period will not constitute an extension of coverage. Blue Cross NC will return any excess premium payments. When Blue Cross NC decides at its sole discretion to accept a late premium

payment, Blue Cross NC will reinstate your coverage back to the date of termination rather than return such premium payment provided that all outstanding fees have been paid.

COVERED SERVICES

This section provides a more complete description of your benefits, along with some exceptions – or services that aren't covered by your health benefit plan. Keep in mind as you read this section Blue Options covers only those services that are MEDICALLY NECESSARY. Also check the "Summary of Benefits" for any benefit maximums and limitations that may apply to your benefits. We've grouped these COVERED SERVICES listed below to make it easier for you to find what you're looking for.

Table of Contents:

- Office Services
- PREVENTIVE CARE
- Obesity Treatment/Weight Management
- EMERGENCY and Ambulance Services
- URGENT CARE
- HOSPITAL and Other Facility Care
- Alternatives to HOSPITAL Stays
- Family Planning
- Specific Therapies and Tests
- Other Services
- Equipment and Supplies
- Surgical Benefits
- Mental Health/Substance Use Disorder Services
- PRESCRIPTION DRUG Benefits

Key Words:

- OFFICE VISIT
- OUTPATIENT CLINIC
- PREVENTIVE CARE
- IN-NETWORK
- OUT-OF-NETWORK
- REHABILITATIVE THERAPY/HABILITATIVE SERVICES
- GENERIC and BRAND-NAME PRESCRIPTION DRUGS

Office Services

Your health benefit plan covers care you receive as part of an OFFICE VISIT, including:

- electronic visit
- evaluation and treatment of obesity
- house call
- telehealth services

Telehealth services from Teladoc: Telehealth services from Teladoc include evaluation, management and consultation services for behavioral health and non-EMERGENCY medical issues with a PROVIDER via an interactive audio/video or audio-only telecommunications system. See Teladoc in "Who to Contact?" to access a DOCTOR who can diagnose and recommend treatment. Telehealth services from Teladoc will be subject to the copayment and/or coinsurance and any applicable deductible listed in your "Summary of Benefits."

Telehealth services from a local PROVIDER: You can also check with your PROVIDER to see if telehealth services are available. Telehealth services are available IN-NETWORK and OUT-OF-NETWORK and are separate from your telehealth benefit with Teladoc. Telehealth services include, but are not limited to, evaluation, management, and consultative services

for medical, counseling, and care management issues with a PROVIDER via an interactive audio/video or other telecommunications system. It is important to understand that your benefit will vary depending upon the type of PROVIDER you see for these services.

Your health benefit plan also covers infusion services received at an AMBULATORY INFUSION SUITE. Certain infusion services require PRIOR REVIEW and CERTIFICATION or services will not be covered.

A copayment will not apply if you only receive services such as allergy shots or other injections and are not charged for an OFFICE VISIT; however, coinsurance will apply.

Some DOCTORS or OTHER PROVIDERS may practice in HOSPITAL–based or OUTPATIENT CLINICS or provide HOSPITAL-based services in their offices. These services are covered as outpatient services and are listed as HOSPITAL-based or OUTPATIENT CLINIC.

Some PROVIDERS may get ANCILLARY SERVICES, such as laboratory services, medical equipment and supplies or SPECIALTY DRUGS, from third parties. In these cases, you may be billed directly by the ANCILLARY PROVIDER. Benefit payments for these services will be based on the type of ANCILLARY PROVIDER, its network status, and how the services are billed.

PREVENTIVE CARE

This health benefit plan covers PREVENTIVE CARE services that can help you stay safe and healthy.

PREVENTIVE CARE services may fall into three categories: (1) federally-mandated PREVENTIVE CARE services (required to be covered at no cost to you IN-NETWORK); (2) state-mandated PREVENTIVE CARE services (required to be offered both IN- and OUT-OF-NETWORK); and (3) non-mandated PREVENTIVE CARE services. In order to determine your benefit, it is important to understand what type of PREVENTIVE CARE service you are receiving, where you are receiving it and why you are receiving it.

Federally-Mandated PREVENTIVE CARE Services

Under federal law, you can receive certain covered PREVENTIVE CARE services from an IN-NETWORK PROVIDER in an office-based, outpatient, ambulatory surgical setting, or URGENT CARE center at no cost to you. Please log on to the website at **www.BlueCrossNC.com/preventive** or call the number in "Who to Contact?" for the most up-to-date information on PREVENTIVE CARE that is covered under federal law, including general preventive services and screenings, immunizations, well-baby/well-child care, women's PREVENTIVE CARE, nutritional counseling visits, and certain over-the-counter medications. Nutritional counseling visits are separate from the obesity-related OFFICE VISITS noted in the "Summary of Benefits." Certain over-the-counter medications are covered only as indicated and when a PROVIDER'S PRESCRIPTION is presented at a pharmacy.

The following conditions must be met for these services to be covered at no cost to you IN-NETWORK: