BlueCross BlueShield of North Carolina

Vaya Health

Effective July 1, 2019

Blue Options[SM] ASO

Prepared By

MARK BROWDER

Prospect # 349640

The benefit highlight is a summary of Blue Options[SM] 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[SM] 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[SM] benefit booklet from Blue Cross NC Customer Service.

Blue Options[SM] Benefit Highlights (PPO)

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

Deductibles, Out-of-Pocket Limits & Benefit Maximums *The following Deductibles, Out-of-Pocket Limits, and Benefit Maximums apply to all services. All copays are before deductible.*	**In-network**	**Out-of-network** [1]
Embedded Deductibles		
Individual (per Benefit Period)	$ 1,000	$ 2,000
Family (per Benefit Period)	$ 2,000	$ 4,000
Embedded Out-of-Pocket Limits		
Individual (per Benefit Period)	$ 2,350	$ 4,700
Family (per Benefit Period)	$ 4,700	$ 9,400
Benefit Maximums:		
Lifetime Total Dollar Maximum	Unlimited	Unlimited
Lifetime Infertility Benefit Maximum		
Ovulation Induction Cycles *(with insemination, per Member, in all places of service)*	3 Cycle Limits	
Annual Benefit Maximums: *Maximums apply to Home, Office and Outpatient Settings only, unless otherwise indicated. Maximums include both Habilitative and Rehabilitative services unless otherwise indicated. All maximums are on a combined In- and Out-of-Network basis per Member, per Benefit Period.*		
Physical, Occupational and Chiropractic Therapies (combined)	30 visits	
Speech Therapy	30 visits	
Applied Behavioral Analysis (ABA) Therapy (ages 18 and younger)	$40,000	
Skilled Nursing Facility Stay	60 days	
Provider Office visits for the evaluation and treatment of obesity (maximum does not apply to dietician/nutritional visits)	4	
Physician Office Services *(See "Outpatient Services" for "outpatient clinic" or "hospital-based" services.)*		
Office Visit *Includes all Office Visits regardless of specialty or diagnosis (including medical, mental health, substance abuse, infertility, therapies and pre-natal/post -delivery care unable to be included in the global delivery fee). Includes Office Surgery, Consultation, X-rays and Labs.*		
Primary Care Provider	$35	70% after deductible
Specialist	$70	70% after deductible
Preventive Care (Primary Preventive Diagnosis Only) *For the most updated list of general preventive/screenings, immunizations, well-baby/well-child care, womens preventive care services, nutritional counseling and other services mandated under Federal law, see our website at bcbsnc.com/preventive.*		
Primary Care Provider	100% no deductible	70% after deductible*
Specialist	100% no deductible	70% after deductible*

**Only state mandated services including, but not limited to, colorectal screening, bone mass measurement, newborn hearing screening, prostate specific antigen tests (PSAs), gynecological exams, cervical cancer screening, ovarian cancer screening and screening mammograms are covered Out-of-Network.*

Blue Options[SM] Benefit Highlights (PPO)

Urgent and Emergency Care	In-network	Out-of-network [1]
Urgent Care Centers	$70	$70
Emergency Room Visit*	$500	$500
Ambulance	80% after deductible	80% after deductible

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

Inpatient Hospital Services		
Includes all Inpatient Hospital Services regardless of diagnosis (including, but not limited to, medical, mental health, substance abuse, infertility, therapies, transplants, deliveries, and surgeries.)		
Inpatient Hospital Facility Services	80% after deductible	70% after deductible
Inpatient Hospital Professional Services	80% after deductible	70% after deductible
Outpatient Services		
Hospital Based or Free-standing Facility Services *(other than preventive services above)*	80% after deductible	70% after deductible
Outpatient Diagnostic Services		
Outpatient lab tests when performed alone *(Professional and Facility Services)*	100% no deductible	70% after deductible
Outpatient lab tests when performed with another service		
Professional Services	100% no deductible	70% after deductible
Facility Services	80% after deductible	70% after deductible
Outpatient Mammography	100% no deductible	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEGs and EKGs	80% after deductible	70% after deductible
Other Services		
Skilled Nursing Facility	80% after deductible	70% after deductible
Home Health Care and Hospice	80% after deductible	70% after deductible
Durable Medical Equipment, Prosthetics and Orthotics	80% after deductible	70% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including a physician's office	80% after deductible	70% after deductible

Blue Options[SM] Benefit Highlights (PPO)

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

Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments.
Prescription Drug copayments, coinsurance* and deductibles* (*if applicable) apply to the Out-of-Pocket limit.*
MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed).
Penalty does not count toward OOP Limit. Enhanced 4 Tier Commercial, Broad Plus Network Formulary.
Prior Plan approval, step therapy and quantity limits may apply.

Tier 1 Drugs	$15	$15
Tier 2 Drugs	$45	$45
Tier 3 Drugs	$85	$85
Tier 4 Drugs	75%	75%

There is a $50 per Prescription Minimum and a $200 per Prescription Maximum for each 30-day supply of Tier 4 drugs.
You are responsible for charges over the allowed amount received from an Out-of-Network pharmacy.
Limits apply to Infertility drugs, refer to your benefit booklet.

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

ADDITIONAL INFORMATION ABOUT BLUE OPTIONS℠ FROM BLUE CROSS NC

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

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

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

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

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

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

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

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

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

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

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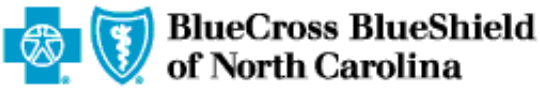
Billing arrangement: ee, ee+spouse, ee+children, fam



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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[SM] with HSA Fund Benefit Highlights (PPO)

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Deductibles, Out-of-Pocket Limits & Benefit Maximums *The following Deductibles, Out-of-Pocket Limits, and Benefit Maximums apply to all services. All copays are before deductible.*	**In-network**	**Out-of-network** [1]
Aggregate Deductibles		
Individual (per Benefit Period)	$2,000	$4,000
Family Member (per Benefit Period)	$4,000	$8,000
Family (per Benefit Period)	$4,000	$8,000
Aggregate Out-of-Pocket Limits		
Individual (per Benefit Period)	$4,000	$8,000
Family Member (per Benefit Period)	$6,550	$13,100
Family (per Benefit Period)	$8,000	$16,000
Benefit Maximums:		
Lifetime Total Dollar Maximum	Unlimited	Unlimited
Lifetime Infertility Benefit Maximum		
Ovulation Induction Cycles *(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.*		
Physical, Occupational and Chiropractic Therapies (combined)	30 visits	
Speech Therapy	30 visits	
Applied Behavioral Analysis (ABA) Therapy (ages 18 and younger)	$40,000	
Skilled Nursing Facility Stay	60 days	
Provider Office visits for the evaluation and treatment of obesity (maximum does not apply to dietician/nutritional visits)	4	
Physician Office Services *(See "Outpatient Services" for "outpatient clinic" or "hospital-based" services.)*		
Office Visit *Includes all Office Visits regardless of specialty or diagnosis (including medical, mental health, substance abuse, infertility, therapies and pre-natal/post -delivery care unable to be included in the global delivery fee). Includes Office Surgery, Consultation, X-rays and Labs.*		
Primary Care Provider	70% after deductible	40% after deductible
Specialist	70% after deductible	40% after deductible
Preventive Care (Primary Preventive Diagnosis Only) *For the most updated list of general preventive/screenings, immunizations, well-baby/well-child care, womens preventive care services, nutritional counseling and other services mandated under Federal law, see our website at bcbsnc.com/preventive.*		
Primary Care Provider	100% no deductible	70% after deductible*
Specialist	100% no deductible	70% after deductible*
**Only state mandated services including, but not limited to, colorectal screening, bone mass measurement, newborn hearing screening, prostate specific antigen tests (PSAs), gynecological exams, cervical cancer screening, ovarian cancer screening and screening mammograms are covered Out-of-Network.*		

Blue Options℠ with HSA Fund Benefit Highlights (PPO)

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

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

Inpatient Hospital Services		
Includes all Inpatient Hospital Services regardless of diagnosis (including, but not limited to, medical, mental health, substance abuse, infertility, therapies, transplants, deliveries, and surgeries.)		
Inpatient Hospital Facility Services	70% after deductible	40% after deductible
Inpatient Hospital Professional Services	70% after deductible	40% after deductible

Outpatient Services		
Hospital Based or Free-standing Facility Services *(other than preventive services above)*	70% after deductible	40% after deductible
Outpatient Diagnostic Services		
Outpatient lab tests when performed alone *(Professional and Facility Services)*	70% after deductible	40% after deductible
Outpatient lab tests when performed with another service		
Professional Services	70% after deductible	40% after deductible
Facility Services	70% after deductible	40% after deductible
Preventive Mammography	100% no deductible	70% after deductible
Diagnostic Mammography	100% after deductible	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEGs and EKGs	70% after deductible	40% after deductible

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

Blue Options[SM] 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 bcbsnc.com/preventive	100% no deductible	100% no deductible

All pharmacy coinsurance amounts below apply after the medical deductible is satisfied, and apply to the medical Out-of-Pocket limit.
MAC C Pricing.
Penalty does not count toward OOP Limit. Enhanced 4 Tier Commercial, Broad Plus Network Formulary.
Prior Plan approval, step therapy and quantity limits may apply.

Prescription drugs	70% after deductible
Enhanced Preventive Drugs	70% no deductible

Generic Drugs from the Enhanced Preventive Drug List prescribed for a preventive reason.
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.

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Benefit Period
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Utilization Management
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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.
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- For investigative or experimental purposes
- For hearing aids or tinnitus maskers, except as specifically covered by the benefit plan
- For cosmetic services or cosmetic surgery
- For custodial care, domiciliary care or rest cures
- For treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- For reversal of sterilization
- For treatment of sexual dysfunction not related to organic disease
- For assisted reproductive technologies as defined by the Centers for Disease Control and Prevention
- For self-injectable drugs in the provider's office

Aggregate Deductible Definition
If you selected Employee Only Coverage, the Employee Deductible and Out-Of-Pocket Limit will apply. If you selected Family Coverage, either the Family Member or Family Total Deductible and Out-of-Pocket Limit will apply. All covered family members contribute to the same Family Total Deductible and the same Family Total Out-of-Pocket Limit, however any individual Family Member who reaches his or her Family Member Deductible and Out-Of-Pocket Limit will have the benefit levels for each apply to them only, and not the entire Family. The Family Total Deductible and Out-Of-Pocket Limit must be met before the respective benefit levels for each are payable for all Family Members, regardless of whether each individual Family Member's Deductible and Out-Of-Pocket Limit has been met.

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.

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Billing arrangement: ee, ee+spouse, ee+children, fam