



SEAC of the Carolinas, LLC.

Effective January 1, 2026

Blue Options
Prepared By
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Prospect # 375491
Quote # 6640700

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.

Blue Options Benefit Highlights (PPO)

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

This Benefit Overview describes your coverage and cost sharing amounts, including deductible, coinsurance, copayments and out-of-pocket maximum, under this plan.

General Cost Share & Features	In-Network	Out-of-Network ¹
Embedded Medical Deductible -Per Benefit Period	\$6,000/Individual \$6,000/Family Member \$12,000/Family	\$12,000/Individual \$12,000/Family Member \$24,000/Family
Coinsurance	40%	70%
Embedded Out-of-Pocket Maximum -Per Benefit Period -Medical and Drug Combined	\$9,500/Individual \$9,500/Family Member \$19,000/Family	\$19,000/Individual \$19,000/Family Member \$38,000/Family

Preventive Care		
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	No Charge	30% after deductible
Specialist	No Charge	30% after deductible
Physician Office Services		
Physician Office Services-Includes all Office Visits regardless of specialty or diagnosis (including medical and infertility therapies and pre-natal/post-delivery care unable to be included in the global delivery fee). Includes Office Surgery, Consultation, and X-rays, unless otherwise specified. (For sinus surgery performed in an office setting, see "Inpatient and Outpatient Services.")		
Primary Care Visit 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.	\$70	70% after deductible
Specialist	\$140	70% after deductible
Mental Health and Substance Use Disorder	\$70	70% after deductible
Vendor Telehealth Includes Telehealth services for Primary Care, Acute Care, Mental Health Teletherapy, Dermatology, and Nutritional Counseling	No Charge	Not Covered
Urgent and Emergency Care		
Emergency Care- 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.		
Ambulance	40% after deductible	40% after deductible
Emergency Room Visit (with or without Observation)	\$2,500	\$2,500
Emergency Room Visit (with Inpatient Admission)	40% after deductible	40% after deductible
Urgent Care Services	\$140	\$280
Inpatient and Outpatient Hospital Services		
Inpatient and Outpatient Hospital Services-Includes all Inpatient Hospital Services regardless of diagnosis (including, but not limited to, medical, mental health, substance use disorder, infertility, therapies, transplants, deliveries, and surgeries). If you receive care at a Blue Distinction® Center (BDC), your out-of-pocket expenses may be less. You may reduce your coinsurance by 10% simply by utilizing an outpatient or inpatient BDC. Please visit https://www.bluecrossnc.com/bdc for more information, including the most up-to-date list of specialties, and to find a BDC near you.		
Ambulatory Surgical Center-Facility	40% after deductible	70% after deductible
Ambulatory Surgical Center-Professional	40% after deductible	70% after deductible
Facility Services	40% after deductible	70% after deductible
Professional Services	40% after deductible	70% after deductible

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Hospital Based Clinics or Free-Standing Facility Services (other than preventive services above)	40% after deductible	70% after deductible
Outpatient Lab Tests	40% after deductible	70% after deductible
Preventive Mammography	No Charge	30% after deductible
Diagnostic Mammography	No Charge	30% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic test such as EEGs and EKGs	40% after deductible	70% after deductible
Other Services		
Skilled Nursing Facility	40% after deductible	70% after deductible
CT Scans, MRIs, MRAs and PET Scans in any location, including a physician's office	40% after deductible	70% after deductible
Durable Medical Equipment, Prosthetics and Orthotics	40% after deductible	70% after deductible
Home Health Care and Hospice	40% after deductible	70% after deductible
Sinus surgeries in any location, including physician's office	40% after deductible	70% after deductible
Pediatric Dental		
Pediatric Dental is only available for members up through the end of the month they become age 19.		
Preventive Services	No Charge	30% after deductible
Basic, Major and Orthodontic Services (if Medically Necessary)	40% after deductible	70% after deductible
Pediatric Vision		
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.		
Routine Vision Exams	No Charge	30% after deductible
Frames and Lenses or Contact Lenses	50% no deductible	50% no deductible

Prescription Drugs		
Prescription Drugs copayments*, coinsurance* and deductibles* (*if applicable) apply to the Out-of-Pocket limit. Up to 30-day supply is one copayment. 31-60 day supply is two copayments and 61-90 day supply is three copayments. 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. MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed). QHP Essential 5-Tier, Broad Network Formulary. Prior Plan approval, step therapy and quantity limits may apply. Diabetic supplies obtained at the pharmacy will apply to a drug tier. Check your benefit booklet for additional details.		
Prescription Drug Cost Share & Features	In-Network	Out-of-Network¹
Prescription Drug Deductible -Per Benefit Period	\$200/Individual	
Tier 1	\$15 after prescription drug deductible	\$15 after prescription drug deductible
Tier 2	\$35 after prescription drug deductible	\$35 after prescription drug deductible
Tier 3	\$45 after prescription drug deductible	\$45 after prescription drug deductible
Tier 4	\$90 after prescription drug deductible	\$90 after prescription drug deductible
Tier 5	25% after prescription drug deductible Minimum: \$90 Maximum: \$200	25% after prescription drug deductible Minimum: \$90 Maximum: \$200
Drugs from the ACA preventive list, including preventive OTC medications and contraceptive drugs and devices, as listed at www.bluecrossnc.com/preventive	No Charge	

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Any Out-of-Network charges over the allowed amount are not included in this maximum.

Lifetime Benefit Maximums	
Lifetime Total Dollar Maximum	Unlimited
Lifetime Infertility Benefit Maximum	
Lifetime Infertility Benefit Maximum- Ovulation Induction Cycles	3 Cycle Limit - With or without insemination, per Member, in all places of service
Annual Benefit Maximums	
Maximums apply to Home, Office and Outpatient Settings only, unless otherwise indicated. Maximums include both Habilitative and Rehabilitative services unless otherwise indicated. All maximums are 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 (Rehabilitative/Habilitative)	30 visits/30 visits
Speech Therapy (Rehabilitative/Habilitative)	30 visits/30 visits
Skilled Nursing Facility	60 days
Provider Office visits for the evaluation and treatment of obesity	4 visits
Nutritional Counseling	30 visits

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

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
- For adult routine eye exams
- Weight Loss Drugs

Allowed Amount

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

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.

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 to any provider outside of North Carolina.

Health and Wellness Program

Your benefits provide access to a variety of wellness programs and services to help you stay healthy. These include nurse support for chronic conditions, pregnancy and behavioral health, as well as tobacco cessation programs and exclusive member discounts on things like gym memberships, glasses, hearing aids and more. You can also access a wide selection of online and digital health and wellness tools and resources at bluecrossnc.com to help you take charge of your health!

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.

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When choosing a prescription drug, you and your doctor should discuss whether a lower-cost prescription drug could provide the same results as a more expensive prescription drug. If you choose a brand-name prescription drug, your cost may be higher. Please note: You may pay a different amount in certain situations when choosing between generic and brand-name prescription 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. For prescription drugs received from an out-of-network pharmacy, you will also pay any charges over the allowed amount. You may not be required to pay the difference between the brand-name allowed amount and the generic allowed amount for certain brand-name prescription drug, if these criteria are met: 1) the brand-name prescription drug is on the Narrow Therapeutic Index (NTI). See [\[ncbop.org/faqs/Pharmacist/faq_NTIDrugs.html\]](http://ncbop.org/faqs/Pharmacist/faq_NTIDrugs.html) for a current list of these drugs; or 2) your provider has required the use of a brand-name prescription drug to treat your condition. Applicable copayment or coinsurance amounts may still apply. From time to time, members may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce prescription drug costs.

Embedded Deductible Definition

This health benefit plan has an embedded deductible. The individual deductible applies if you select individual-only coverage; otherwise, both the family member and family deductible apply. For family coverage, each covered family member has their own family member deductible, in addition to the family deductible. No single family member can contribute more than the family member deductible. If a covered family member meets their family member deductible, benefits are payable by Blue Cross NC for just that member. Once the family deductible is met, it is met for all covered family members.

Embedded Out-of-Pocket Maximum Definition

This health benefit plan has an embedded out-of-pocket limit. The individual out-of-pocket limit applies if you selected individual-only coverage; otherwise, both the family member and family out-of-pocket apply. No single family member can contribute more than their family member out-of-pocket limit. If a covered family member meets their family member out-of-pocket limit, Blue Cross NC will pay 100% of covered services, up to the allowed amount, for just that member. Once the family out-of-pocket limit is met, Blue Cross NC will pay 100% of covered services, up to the allowed amount, for all covered family members.

Prepared For:

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Medical Rate Comparison	
Composite Blue Options Blue Options Bronze (Copay) 6000 Plan 1 01/01/2026	
Benefits	Quote 6640700
Deductible (Individual/Family Member/Family)	
In-Network	\$6000/\$6000/\$12000
Out-of-Network	\$12000/\$12000/\$24000
Maximum Out-of-Pocket (Individual/Family Member/Family)	
In-Network	\$9500/\$9500/\$19000
Out-of-Network	\$19000/\$19000/\$38000
Coinsurance* or Copayment	
In-Network Inpatient Services	40% after deductible
In-Network Outpatient Services	40% after deductible
Out-of-Network IP/OP Services	70% after deductible
Physician Office Visit	
In-Network Primary Care Visit	\$70 copayment
In-Network Specialist Visit	\$140 copayment
In-Network Preventive Care	No Charge
Urgent Care	
In-Network Urgent Care	\$140 copayment
Emergency Room	
Emergency Room Visit with/without Observation	\$2,500 copayment
Emergency Room Visit with Inpatient Admission	40% after deductible
Prescription Drugs	
Prescription Drug Deductible	\$200
Tier 1 Drugs	\$15 copayment
Tier 2 Drugs	\$35 copayment
Tier 3 Drugs	\$45 copayment
Tier 4 Drugs	\$90 copayment
Tier 5 Drugs	25% coinsurance
Tier 5 Minimum/Maximum	\$90/\$200
Total Monthly Premium	\$13,630.03
Estimated Employer Premium Contribution Employee Only	\$6,815.02 @50% \$13,630.03 @100%

*Applicable coinsurance is applied after deductible.