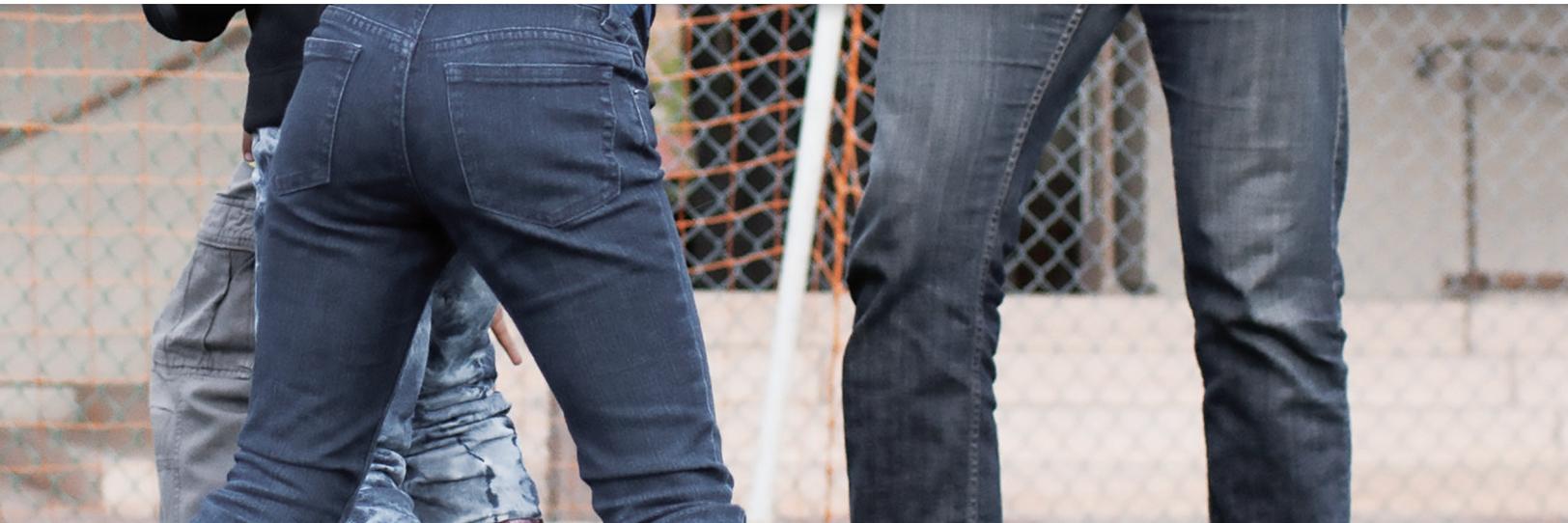


Benefit Highlights



Blue Options 1-2-3 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.

Embedded Deductibles

	In-network	Out-of-network ¹
Individual (per Benefit Period)	\$3,500	\$7,000
Family (per Benefit Period)	\$7,000	\$14,000

Embedded Out-of-Pocket Limits

	In-network	Out-of-network ¹
Individual (per Benefit Period)	\$7,000	\$14,000
Family (per Benefit Period)	\$14,000	\$28,000

Benefit Maximums:

Lifetime Total Dollar Maximum Unlimited Unlimited

Lifetime Infertility Benefit Maximum

Ovulation Induction Cycles 3 Cycle Limits
(with 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.

Physical, Occupational and Chiropractic Therapies (combined)	30 visits
Speech Therapy	30 visits
Adaptive Behavior Treatment is covered for members, up to age 19.	\$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

Level 1

In-network

Out-of-network¹

Preventive Care (See hospital based clinics-Level 3) (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	100% no deductible	70% after deductible
Specialist	100% no deductible	70% after deductible

Primary Care Office-based Services

Includes all Office Visits regardless of 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, X-rays and Labs. For these services provided by a specialist, see Level 3 Benefits.

Primary Care Provider	\$35	50% after deductible
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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.

Vendor Telehealth \$10 Benefits not available

Includes Telehealth services for medical/acute care/behavioral health

Blue Options 1-2-3 Benefit Highlights (PPO)

Level 2	In-network	Out-of-network ¹
Inpatient Hospital Services		
<i>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.</i>		
Hospital and Hospital Based Services	\$250 per admission, then 80% after deductible	\$500 per admission, then 50% after deductible
Inpatient Professional Services		
Professional Services	80% after deductible	50% after deductible
Skilled Nursing Facility	80% after deductible	50% after deductible
Inpatient Home Health Care and Hospice Care	80% after deductible	50% after deductible

Level 3	In-network	Out-of-network ¹
Specialist Office-Based Services		
Professional Services	60% after deductible	50% after deductible
Specialist Outpatient Facility-Based Service		
Professional Services	60% after deductible	50% after deductible
Urgent Care Center Services		\$100
Emergency Room Visit*	60% after deductible	
<i>*If admitted from the ER, any applicable ER member responsibility does not apply; instead, Inpatient Hospital (Level 2) benefits apply. If held for observation, Outpatient (Level 3) benefits apply. 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.</i>		
Outpatient Hospital Services		
	60% after deductible	50% after deductible
<i>Includes hospital and hospital-based services, hospital based clinics, surgery, and outpatient diagnostic services such as lab tests, X-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs, pulmonary function tests, rehabilitative, habilitative and other therapies.</i>		
Outpatient Diagnostic Services		
Outpatient lab tests	60% after deductible	50% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including physician's office,		
Durable Medical Equipment, Home Infusion Therapy, Medical Supplies,		
Orthotic Devices and Prosthetic Appliances	60% after deductible	50% after deductible
Ambulance	60% after deductible	60% after deductible

Blue Options 1-2-3 Benefit Highlights (PPO)

Prescription Drugs

Preventive OTC Medications and Contraceptive

In-network
100% no deductible

Out-of-network¹
100% no deductible

Drugs and Devices as listed at bluecrossnc.com/preventive

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 Network Formulary.

Prior Plan approval, step therapy and quantity limits may apply.

Tier 1 Drugs

\$10

\$10

Tier 2 Drugs

0%

0%

Tier 3 Drugs

0%

0%

Tier 4 Drugs

0%

0%

There is a \$100 per Prescription Maximum for each 30-day supply of Tiers 2, 3, 4 drugs.

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.

¹NOTICE: 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 1-2-3

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.

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Blue Cross NC is an Independent licensee of the Blue Cross and Blue Shield Association

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.

Plan codes: PT70146 R041230 MT1800 ST1800 C000100 V000100 D000100
Facets codes: MED-FS003486 (base) DRU-BR002135 (base)
Billing arrangement: ee, ee+spouse, ee+children, fam

NON-DISCRIMINATION AND ACCESSIBILITY NOTICE

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides:

- + Free aids and services to people with disabilities to communicate effectively with us, such as: qualified interpreters and/or written information in other formats (large print, audio, accessible electronic formats, other formats.)
- + Free language services to people whose primary language is not English, such as: qualified interpreters and/or information written in other languages

If you need these services, contact:

Customer Service

Call: 1-888-206-4697, 1-800-442-7028 (TTY and TDD)

If you believe that Blue Cross NC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Cross NC, P.O. Box 2291, Durham, NC 27702

**Attention: Civil Rights Coordinator-Privacy,
Ethics & Corporate Policy Office**

Call: 919-765-1663, 1-888-291-1783 (TTY)

Fax: 919-287-5613

E-mail: civilrightscordinator@bcbsnc.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Coordinator-Privacy, Ethics & Corporate Policy Office is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Online: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>

Mail: U.S. Department of Health & Human Services

200 Independence Avenue, SW Room 509F

HHH Building Washington, D.C. 20201

Call: 1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available online at:

<http://www.hhs.gov/civil-rights/filing-a-complaint/index.html>

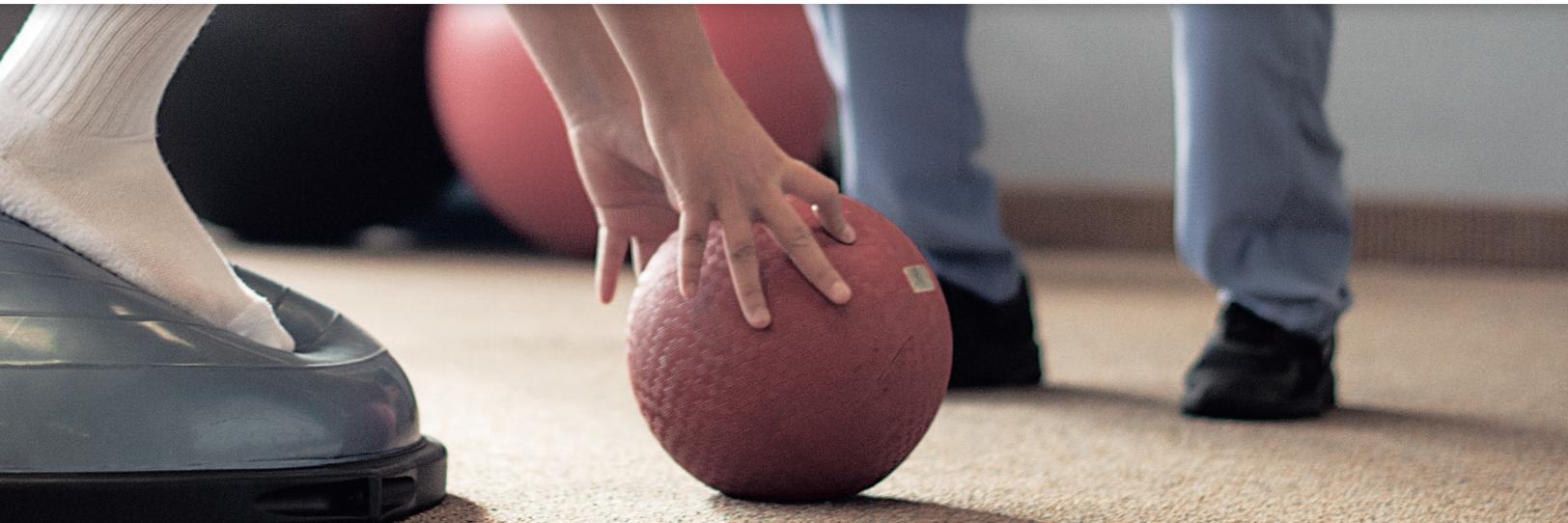
This notice and/or attachments may have important information about your application or coverage through Blue Cross NC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call **Customer Service: 1-888-206-4697**.

Discrimination is Against the Law

Blue Cross NC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Blue Cross NC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Benefit Highlights



Blue Options 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.

Embedded Deductibles

	In-network	Out-of-network ¹
Individual (per Benefit Period)	\$3,500	\$7,000
Family (per Benefit Period)	\$10,500	\$21,000

Embedded Out-of-Pocket Limits

	In-network	Out-of-network ¹
Individual (per Benefit Period)	\$8,550	\$17,100
Family (per Benefit Period)	\$17,100	\$34,200

Benefit Maximums:

Lifetime Total Dollar Maximum Unlimited Unlimited

Lifetime Infertility Benefit Maximum

Ovulation Induction Cycles 3 Cycle Limits
(with 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.

Physical, Occupational and Chiropractic Therapies (combined)	30 visits
Speech Therapy	30 visits
Adaptive Behavior Treatment is covered for members, up to age 19.	\$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 use disorder, 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	50% 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	50% after deductible
Mental Health and Substance Use Disorder	\$10	50% 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	100% no deductible	70% after deductible
Specialist	100% no deductible	70% after deductible

Blue Options Benefit Highlights (PPO)

Urgent and Emergency Care

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

**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 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	70% after deductible	50% after deductible
Inpatient Hospital Professional Services	70% after deductible	50% after deductible

Outpatient Services

Hospital Based or Free-standing Facility Services <i>(other than preventive services above)</i>	70% after deductible	50% after deductible
Outpatient Diagnostic Services		
Outpatient lab tests	70% after deductible	50% after deductible
Outpatient Mammography	100% no deductible	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEGs and EKGs	70% after deductible	50% after deductible

Other Services

Skilled Nursing Facility	70% after deductible	50% after deductible
Home Health Care and Hospice	70% after deductible	50% after deductible
Durable Medical Equipment, Prosthetics and Orthotics	70% after deductible	50% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including a physician's office	70% after deductible	50% after deductible

Blue Options Benefit Highlights (PPO)

Prescription Drugs

Preventive OTC Medications and Contraceptive

In-network
100% no deductible

Out-of-network¹
100% no deductible

Drugs and Devices as listed at bluecrossnc.com/preventive

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 Network Formulary.

Prior Plan approval, step therapy and quantity limits may apply.

Tier 1 Drugs

\$10

\$10

Tier 2 Drugs

0%

0%

Tier 3 Drugs

0%

0%

Tier 4 Drugs

0%

0%

There is a \$100 per Prescription Maximum for each 30-day supply of Tiers 2, 3, 4 drugs.

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.

¹NOTICE: 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

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.

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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.

Plan codes: PB90342 R041230 MP90016 SP90016 C003400 V000100 D000100
Facets codes: MED-FS003340 (base) DRU-BR002135 (base)
Billing arrangement: ee, ee+spouse, ee+children, fam

NON-DISCRIMINATION AND ACCESSIBILITY NOTICE

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides:

- + Free aids and services to people with disabilities to communicate effectively with us, such as: qualified interpreters and/or written information in other formats (large print, audio, accessible electronic formats, other formats.)
- + Free language services to people whose primary language is not English, such as: qualified interpreters and/or information written in other languages

If you need these services, contact:

Customer Service

Call: 1-888-206-4697, 1-800-442-7028 (TTY and TDD)

If you believe that Blue Cross NC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Cross NC, P.O. Box 2291, Durham, NC 27702

**Attention: Civil Rights Coordinator-Privacy,
Ethics & Corporate Policy Office**

Call: 919-765-1663, 1-888-291-1783 (TTY)

Fax: 919-287-5613

E-mail: civilrightscordinator@bcbsnc.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Civil Rights Coordinator-Privacy, Ethics & Corporate Policy Office is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

Online: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>

**Mail: U.S. Department of Health & Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201**

Call: 1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available online at:

<http://www.hhs.gov/civil-rights/filing-a-complaint/index.html>

This notice and/or attachments may have important information about your application or coverage through Blue Cross NC. Look for key dates. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call **Customer Service: 1-888-206-4697**.

Discrimination is Against the Law

Blue Cross NC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Blue Cross NC does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.



Dental Blue Preferred (PPO) Benefit Highlights - Traditional Plan

Services	In-network	Out-of-network
Preventive Care Routine Oral Exams, Cleanings, Bitewing X-rays, Fluoride Application, Sealants, Space Maintainers	100%	80%
Basic Care Routine Fillings, Simple Extractions, Endodontics	80% after Dental deductible	60% after Dental deductible
Major Care Crowns, Inlays and Onlays, Dentures, Periodontics	50% after Dental deductible	50% after Dental deductible
Benefit Period Deductible (Applies to Basic and Major Care)		
Individual	\$25	\$25
Family	\$75	\$75
Combined Benefit Period Maximum <i>(Includes Diagnostic and Preventive, Basic and Major Restorative Care)</i>	\$1,000	\$1,000
Orthodontic Care <i>Covered through age 18</i>	50%	50%
Lifetime Orthodontic Maximum	\$1,000	\$1,000

Some services may have frequency limitations. For example 3 exams and cleanings per benefit period, replacements of crowns & dentures every 8 years.

ADDITIONAL INFORMATION ABOUT DENTAL BLUE PREFERRED (PPO) 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.

Waiting Period

A waiting period is the amount of time that a member must be enrolled in this dental benefit plan prior to receiving specific services. Waiting periods may apply to some services if the group or member does not have evidence of prior dental coverage.

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

- Not medically necessary
- Hospitalization for any dental procedure
- Dental procedures solely for cosmetic or aesthetic reasons
- Dental procedures not directly associated with dental disease
- Procedures that are considered to be experimental
- Drugs or medications obtainable with or without a prescription unless they are dispensed and utilized in the dental office during the patient visit
- Services related to temporomandibular joint (TMJ)
- Expenses for dental procedures begun prior to the member's eligibility with Blue Cross NC
- Clinical situations that can be effectively treated by a more cost effective, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure
- Dental implants, oral orthotic devices, palatal expanders and orthodontics except as specifically covered by your dental benefit plan

The benefit highlights is a summary of dental benefits. This is meant only to be a summary. Final interpretation 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 benefit booklet from Blue Cross NC Customer Service.

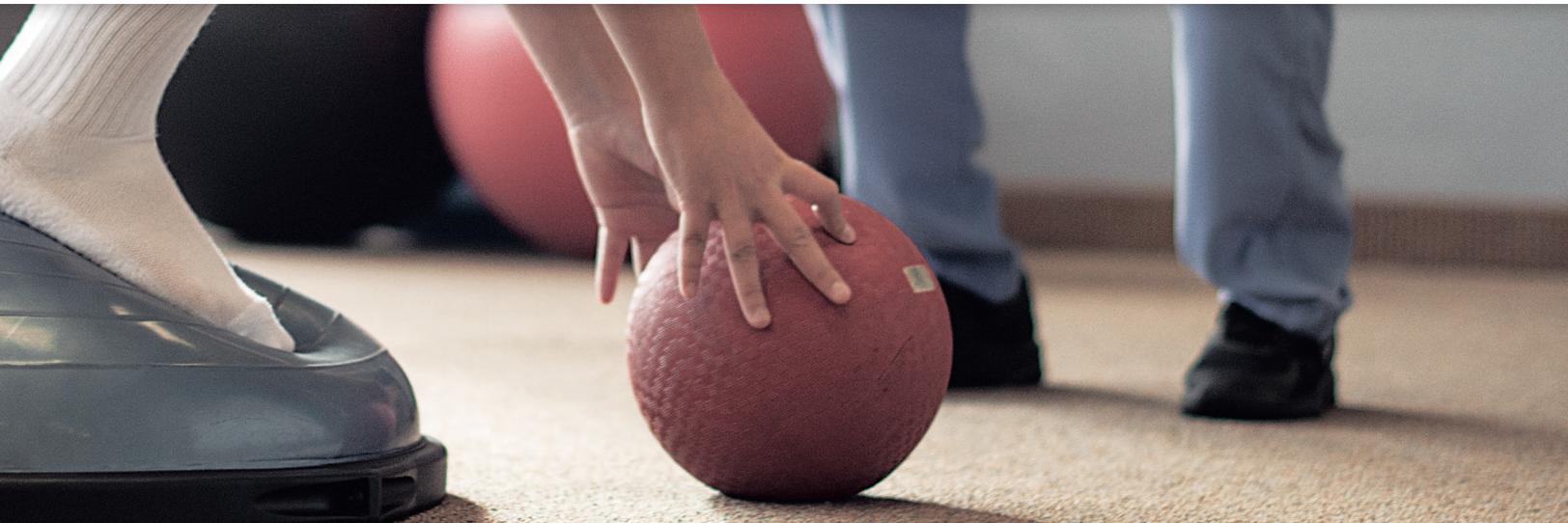
Plan code: DBP6186
Facets code: DEN-B1001386 (base)
Billing arrangement: ee, ee+spouse, ee+children, fam

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LIVINGSTONE COLLEGE

Prospect 70362, Quote 5600298 Effective Date: 10/2021 Quote Date: 04/13/2021

Benefit Highlights



Benefit Highlights - Blue 20/20 Exam Plus

Benefits	In-Network Copayment or Allowance	Out-of-Network Reimbursement
Routine Eye Exam	\$10 Copayment	Provider's billed charge or \$39, whichever is less
Frames	\$130 Allowance	Provider's billed charge, or 50% of your In-Network Allowance, whichever is less
Lenses * *See plan highlight for additional lens options/copayment Or Contact Lenses** Progressive lenses may have additional costs outside your regular vision benefit plan. Contact lenses include both conventional and disposable contact lenses. **Allowance amount is for materials only and does not include fittings for contact lenses or follow-up services	\$25 Copayment \$130 Allowance	Provider's billed charge or single vision \$25, bi-focal \$39, tri-focal and lenticular \$63, whichever is less Provider's billed charge, or 80% of your In-Network Allowance for Contact Lenses, whichever is less
Medically required contact lenses* *Subject to eligibility review	\$0 Copayment	Provider's billed charge or \$200, whichever is less
Frequency Exam	1 per 12 months (Exam)	
Lenses or Contact Lenses / Frames	1 per 12 months (Lenses or Contact Lenses) 1 per 24 months (Frames)	
Voluntary or Non Voluntary	Voluntary	

Please Note:

Additional discounts may be offered at participating retail and provider locations. Please check provider locator for participation.

Plan Exclusions:

- 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; structures;
- 2) Medical and/or surgical treatment of the eye, eyes or supporting structures
- 3) Any eye or vision examination, or any corrective eyewear required by a Policyholder as a condition of employment i.e. Safety eyewear
- 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
- 5) Cosmetic (non-prescription) lenses and/or contact lenses;
- 6) Non-prescription sunglasses;
- 7) Two pair of glasses in lieu of bifocals;
- 8) Services or materials provided by any other group benefit plan providing vision care;
- 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.
- 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.
- 11) Certain brand name vision materials in which the manufacturer imposes a no-discount practice
- 12) Fees charged by a provider for services other than a covered benefit must be paid-in-full by the insured person; such fees or materials are not covered under the policy.