NORTH CAROLINA EHB BENCHMARK PLAN

SUMMARY INFORMATION

Plan Type	Plan from largest small group product, Preferred Provider Organization
Issuer Name	Blue Cross and Blue Shield of NC
Product Name	Blue Options
Plan Name	Blue Options
Supplemented Categories (Supplementary Plan Type)	• Pediatric Oral (FEDVIP) • Pediatric Vision (FEDVIP)
Habilitative Services Included Benchmark (Yes/No)	No
Habilitative Services Defined by State (Yes/No)	No

BENEFITS AND LIMITS

Row Number	A Benefit	B Covered (Required): Is benefit Covered or Not Covered	C Benefit Description (Required if benefit is Covered): Enter a Description, it may be the same as the Benefit name	D Quantitative Limit on Service? (Required if benefit is Covered): Select "Yes" if Quantitative Limit applies	E Limit Quantity (Required if Quantitative Limit is "Yes"): Enter Limit Quantity	F Limit Units (Required if Quantitative Limit is "Yes"): Select the correct limit units	G Other Limit Units Description (Required if "Other" Limit Unit): If a Limit Unit of "Other" was selected in Limit Units, enter a description	H Minimum Stay (Optional): Enter the Minimum Stay (in hours) as a whole number	I Exclusions (Optional): Enter any Exclusions for this benefit	J Explanation: (Optional) Enter an Explanation for anything not listed	K Does this benefit have additional limitations or restrictions? (Required if benefit is Covered): Select "Yes" if there are additional limitations or restrictions that need to be described
1	**Primary Care Visit to Treat an Injury or Illness**	Covered	Primary Care Visit Includes services such as: -Allergy testing -Office surgery -Drugs that must be administered by a provider	No					Prescription drugs that can be self-administered.		No
2	**Specialist Visit**	Covered	Specialist visit Includes services such as: -Allergy testing -Office surgery -Drugs that must be administered by a provider	No					Prescription drugs that can be self-administered.		No
3	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Covered	Includes: Drugs that must be administered by a provider Includes nutritional counseling for ESRD	No							No
4	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Covered	Outpatient surgeries and procedures including: -Reconstructive surgery -Reconstructive procedures -Internal prosthesis -Voluntary male sterilization -Termination of pregnancy	No							No
5	**Outpatient Surgery Physician/Surgical Services**	Covered	Outpatient surgeries and procedures including: -Reconstructive surgery -Reconstructive procedures -Internal prosthesis -Voluntary male sterilization -Termination of pregnancy	No							No

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6	**Hospice Services**	Covered	Hospice Services	No					Homemaker services such as: -Cooking -Housekeeping -Food or meal preparation	Requires life expectancy of 6 months or less.	No
7	**Non-Emergency Care When Traveling Outside the U.S.**	Covered	Non-Emergency Care When Traveling Outside the U.S.	No							No
8	**Routine Dental Services (Adult)**	Not Covered									
9	**Infertility Treatment**	Covered	Services to diagnose cause of infertility, services for or related to artificial insemination, care needed to correct an underlying cause of infertility.	Yes	5000	Other	$5000 per member per lifetime		Services for or related to invitro-fertilizaion, GIFT, ZIFT and reversal of voluntary sterilization. No coverage for dependent children Infertility resulting from menopause Ovum or embryo placement Intracytoplasmic sperm injection (ICSI). Donor eggs and sperm. Surrogate mothers.		No
10	**Long-Term/Custodial Nursing Home Care**	Not Covered									
11	**Private-Duty Nursing**	Covered	Private Duty Nursing	No						Private duty nursing must provide more individual and continuous skilled care than can be provided in a skilled nursing visit through a home health agency.	No
12	**Routine Eye Exam (Adult)**	Covered	Routine screening and refraction	Yes	1	Visits per year					No
13	**Urgent Care Centers or Facilities**	Covered	Urgent care centers	No							No
14	**Home Health Care Services**	Covered	Home health care services	No					Homemaker services, such as cooking and housekeeping. Dietician services or meals.		No

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15	**Emergency Room Services**	Covered	Emergency room services	No							No
16	**Emergency Transportation/ Ambulance**	Covered	Ground transportation to the hospital and between facilities and air ambulance when necessary.	No					Transportation for convenience or comfort or any non-medically necessary conditions.		No
17	**Inpatient Hospital Services (e.g., Hospital Stay)**	Covered	Inpatient surgeries and procedures including: -Reconstructive surgery -Reconstructive procedures -Internal prosthesis -Voluntary male sterilization -Termination of pregnancy -Intensive care units	No					Admissions primarily for the purpose of receiving rehab therapy.		No
18	**Inpatient Physician and Surgical Services**	Covered	Inpatient surgeries and procedures including: -Reconstructive surgery -Reconstructive procedures -Internal prosthesis -Voluntary male sterilization -Termination of pregnancy -Intensive care units -Rehab services	No						Therapy limits do not apply when inpatient.	No
19	**Bariatric Surgery**	Covered	Bariatric services	No							No
20	**Cosmetic Surgery**	Not Covered								Reconstructive surgery is covered.	
21	**Skilled Nursing Facility**	Covered	Skilled nursing facility	Yes	60	Days per year					No
22	**Prenatal and Postnatal Care**	Covered	Includes: -Pregnancy testing when performed in physician office -Complications of pregnancy	No					Services related to surrogacy. No coverage for dependents except for mandated complications of pregnancy.		No
23	**Delivery and All Inpatient Services for Maternity Care**	Covered	Includes: -Complications of pregnancy -Anesthesia -Newborn nursery and care -Neonatal intensive care unit -Circumcision	No					Dependent maternity except for state mandated complications of pregnancy and federally mandated services. Services related to surrogacy.		No

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24	**Mental/Behavioral Health Outpatient Services**	Covered	Includes: -Evaluation and diagnosis -Medically necessary biofeedback -Neuro psychological testing -Partial day hospitalization -Intensive therapy services	No					Marital counseling		No
25	**Mental/Behavioral Health Inpatient Services**	Covered	Mental/behavioral health inpatient services	No					Inpatient residential treatment centers. Supervised living.		No
26	**Substance Abuse Disorder Outpatient Services**	Covered	Includes: -Evaluation and diagnosis -Partial day hospitalization -Intensive therapy services	No							No
27	**Substance Abuse Disorder Inpatient Services**	Covered	Inpatient services Including: -Inpatient residential treatment centers -Detoxification	No					Inpatient residential treatment centers. Supervised living.		No
28	**Generic Drugs**	Covered	Generic drugs	No							No
29	**Preferred Brand Drugs**	Covered	Preferred brand drugs	No							No
30	**Non-Preferred Brand Drugs**	Covered	Non-preferred brand drugs	No							No
31	**Specialty Drugs**	Covered	Specialty drugs	No							No
32	**Outpatient Rehabilitation Services**	Covered	Outpatient therapy	No					Cognitive therapy.	These outpatient rehab services have limitations. They will be listed on the separately on the next tab.	Yes
33	**Habilitation Services**	Not Covered	Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking, talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.								

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34	**Chiropractic Care**	Covered	Chiropractic care Includes spinal manipulation	Yes	30	Visits per year				Combined with physical and occupational therapies.	No
35	**Durable Medical Equipment**	Covered	Durable medical equipment Includes: -Orthotics -Prosthetics -Medical devices -Medical equipment and supplies	No					-Wigs -Items of personal comfort -Home exercise -Pools, whirlpools, spas, hydrotherapy equipment -Surgical supports, corsets, clothing unless for the purpose of recovery from surgery or injury -Common first aid supplies -Health club membership		Yes
36	**Hearing Aids**	Covered	Hearing aids	Yes	1	Other	State mandated benefit: for members under age 22, one hearing aid per hearing impaired ear, and replacement hearing aids. Once every 36 months. $2500 per hearing impaired ear every 36 months.				No
37	**Diagnostic Test (X-Ray and Lab Work)**	Covered	Diagnostic test (x-ray and lab work)	No							No
38	**Imaging (CT/PET Scans, MRIs)**	Covered	Imaging (CT/PET Scans, MRIs)	No							No

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39	**Preventive Care/ Screening/ Immunization**	Covered	Includes: -Preventative health care services mandated by ACA -PSA -Routine hearing test -Oral contraceptives -Contraceptive-IUD -Contraceptives - injection -Contraceptive-patch -Contraceptive-diaphragm -Contraceptive-implant -Comprehensive lactation support and counseling by trained provider for pregnant women and those in the postpartum period -Purchase of lactation equipment -Screening and counseling for interpersonal and domestic violence -Pediatric preventive services mandated by the ACA	No						Purchase of lactation equipment was covered as of 8/1 implementation of ACA women's preventive mandate.	No
40	**Routine Foot Care**	Covered	Routine foot care only for persons diagnosed with diabetes.	No					Routine foot care that is palliative or cosmetic.		No
41	**Acupuncture**	Not Covered									
42	**Weight Loss Programs**	Not Covered									
43	**Routine Eye Exam for Children**	Covered	Routine eye exam	Yes	1	Visits per year					No
44	**Eye Glasses for Children**	Covered	Eyeglasses for adults and children	Yes	1	Other	1 pair of glasses (lenses and frames per year				No
45	**Dental Check-Up for Children**	Covered	Dental Exams	Yes	1	Other	1 every 6 months			Limitations, including dollar limits, may apply.	No

OTHER BENEFITS

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1	**Outpatient Rehabilitation Services**	Covered	Cardiac rehab	Yes	30	Visits per year				More available beyond the initial allotment if deemed medically necessary.	No
2	**Outpatient Rehabilitation Services**	Covered	Pulmonary rehab	Yes	1	Other	One course of treatment per year		Group classes		No
3	**Outpatient Rehabilitation Services**	Covered	Physical therapy	Yes	30	Visits per year				Visit limit combined with occupational therapy and chiropractic therapy.	No
4	**Outpatient Rehabilitation Services**	Covered	Occupational therapy	Yes	30	Visits per year				Visit limit combined with physical therapy and chiropractic therapy.	No
5	**Outpatient Rehabilitation Services**	Covered	Speech therapy	Yes	30	Visits per year			Speech therapy for stuttering is not covered		No
6	**Other**	Covered	Renal Dialysis/Hemodialysis	No							No
7	**Other**	Covered	Radiation Therapy	No							No
8	**Other**	Covered	Chemotherapy	No							No
9	**Durable Medical Equipment**	Covered	Orthotic device for positional plagiocephaly	Yes	600	Other	$600 lifetime maximum				No
10	**Other**	Covered	Cochlear implants	No							No

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11	**Other**	Covered	Dental	No						Services provided for anesthesia and facility charges related to dental procedures performed in a hospital or ambulatory surgical center. This benefit is only available to DEPENDENT CHILDREN below the age of nine years, persons with serious mental or physical conditions and persons with significant behavioral problems. The treating PROVIDER must certify that the patient's age, condition or problem requires hospitalization or general anesthesia in order to safely and effectively perform the procedure. Accidental injury of the natural teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth CONGENITAL deformity, including cleft lip and cleft palate. Removal of: - tumors - cysts which are not related to teeth or associated dental procedures - exostoses for reasons other than for preparation for dentures.	No
12	**Other**	Covered	TMJ Includes: Diagnostic, theraputic or surgical procedures Surgical correction of malocclusion Splinting Intraoral prosthetic appliances	No					Treatment for periodontal disease Dental implants or root canals Crowns and bridges Orthodontic braces Occlusal (bite) adjustments Extractions		No

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13	**Other**	Covered	Organ Transplants	No					Investigational transplant services. Purchase price of any organ or tissue. Donor services if the recipient is not a member. Services for or related to the transplantation of animal or artificial organs or tissues.	Includes: -Hematopoietic stem-cell -Cardiac -Heart-Lung -Lung and Lobar Lung -Pancreas -Renal -Small Bowel -Small Bowel with Liver -Multi Visceral -Islet Cell -Liver -Donor Search -Transportation and Lodging -Recipient must be a member	Yes
14	**Other**	Covered	Organ Donor Search	Yes	10000	Other	$10000 per transplant			Services related to the search for a living donor for a member recipient.	No
15	**Other**	Covered	Basic Dental Care – Child	No						Limitations, including dollar limits, may apply	No
16	**Other**	Covered	Major Dental Care – Child	No						Limitations, including dollar limits, may apply	No
17	**Other**	Covered	Orthodontia - Child	No						Limitations, including dollar limits, may apply	No

PRESCRIPTION DRUG EHB-BENCHMARK PLAN BENEFITS BY CATEGORY AND CLASS