BlueCross BlueShield

Administered by Blue Cross and Blue Shield of North Carolina

Traditional HDHP $1,500 / $3,000 Plan

The following is a summary of your benefits coverage. Please refer to your Summary Plan Description for all benefits coverage questions.

Benefit	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible (amount paid by member per plan year)[1]		
Individual Deductible per Year[1] *Rx cost-share does apply to the Deductible*	$1,500	$3,000
Family Deductible per Year[1] *Rx cost-share does apply to the Deductible*	$3,000	$6,000
Coinsurance (amount paid by the member after the deductible)		
	20%	40%
Maximum out-of-pocket (MOOP) limits (amount paid by member, including deductible, copays and coinsurance per plan year) for medical and pharmacy expenses combined)[2,3]		
Individual Out-of-Pocket Limit per Year[2,3] *Copayments, Coinsurance, Deductibles, and Rx apply*	$3,000	$6,000
Family Out-of-Pocket Limit per Year[2,3] *Copayments, Coinsurance, Deductibles, and Rx apply*	$6,000	$12,000
Lifetime maximum benefit		
	Unlimited	Unlimited
Hospital/Facility Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Inpatient Hospitalization[4]	20% after Deductible	40% after Deductible
Outpatient Hospital Facility	20% after Deductible	40% after Deductible
Ambulatory Surgical Center - Outpatient Surgery	20% after Deductible	40% after Deductible
Physician Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Office Visits - Primary Care *(including tests, lab/x-rays; excluding advanced imaging)*	20% after Deductible	40% after Deductible
Office Visits - Specialist *(including tests, lab/x-rays; excluding advanced imaging)*	20% after Deductible	40% after Deductible
Allergy Injections	20% after Deductible	40% after Deductible
Allergy testing and serum	20% after Deductible	40% after Deductible
Surgery performed in the physician's office	20% after Deductible	40% after Deductible
Emergency room physician services (True emergency)	20% after Deductible	20% after In-Network Deductible
Emergency room physician services (Non-emergency)	20% after Deductible	40% after Deductible
Outpatient Physician Visits	20% after Deductible	40% after Deductible
Inpatient Physician Visits	20% after Deductible	40% after Deductible
Maternity Office Visits	20% after Deductible	40% after Deductible
***Adult Routine Physical Exam (18 years and above)**	$0 Cost-Share	40% after Deductible
***Well Child Care (to age 18)**	$0 Cost-Share	40% after Deductible
***Routine Immunizations**	$0 Cost-Share	40% after Deductible

Diagnostic Services (Lab and Radiology)	In-Network (You Pay)	Out-of-Network (You Pay)
Preventive Lab and Radiology (i.e. routine lab tests/x-rays associated w/ routine exams, routine pap, routine mammogram, routine endoscopic services- including colonoscopy)	$0 Cost-Share	40% after Deductible
Tests, Lab, X-ray, Pathology *Office Setting / Freestanding Facility*	20% after Deductible	40% after Deductible
Tests, Lab, X-ray, Pathology *Hospital Facility*	20% after Deductible	40% after Deductible
Advanced Imaging (MRI, MRA, CT, SPECT, PET Scans)[4] *All Office Settings, Freestanding Facility, Hospital Setting*	20% after Deductible	40% after Deductible
Endoscopic Services (non-preventive) *Hospital Setting*	20% after Deductible	40% after Deductible
Emergency Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Emergency Room Facility Fee (True emergency)	20% after Deductible	20% after In-Network Deductible
Emergency Room Facility Fee (Non-emergency)	20% after Deductible	40% after Deductible
Ambulance (in-network benefits paid if medical emergency)	20% after Deductible	40% after Deductible
Urgent Care	20% after Deductible	40% after Deductible
Other Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
Chiropractic Services[5] *30 visits per plan year*	20% after Deductible	40% after Deductible
Durable Medical Equipment	20% after Deductible	40% after Deductible
Home Health Care[4,5] *Limited to 100 visits per plan year.*	20% after Deductible	40% after Deductible
Therapy Services: Occupational, Physical, Speech, Hearing, and Cognitive Therapy (Office, Freestanding, OP)[4,5] *Limited to 60 visits per plan year, combined.*	20% after Deductible	40% after Deductible
Therapy Services: Occupational, Physical, Speech, Hearing, and Cognitive Therapy (Inpatient)[4,5] *Limited to 60 visits per plan year, combined.*	20% after Deductible	40% after Deductible
Skilled nursing facility[4,5] *60 days per plan year*	20% after Deductible	40% after Deductible
Hospice services (Inpatient/Outpatient)[4]	20% after Deductible	40% after Deductible
Transplant services[4]	20% after Deductible	40% after Deductible
Fertility counseling and treatment (up to $10,000 lifetime limit)[6]	20% after Deductible	40% after Deductible
Morbid obesity treatment (including limited covered surgical procedures up to $10,000 lifetime limit)[4,6]	20% after Deductible	40% after Deductible
Hearing aids (covered up to $1,400 per ear every 3 plan years)	20% after Deductible	40% after Deductible
Acupuncture (up to 12 visits per plan year)[5,7]	20% after Deductible	20% after In-Network Deductible
Nutrition / Dietitian counseling for: **-Diabetes and obesity** **-Eating disorders, cancer, celiac disease, rheumatoid arthritis, and inflammatory bowel disease**	$0 Cost-Share (Diabetes & Obesity) 20% after Deductible (Other covered diagnoses)	40% after Deductible
Oral Contraceptives and contraceptive supplies and devices[8]	$0 Cost-Share	40% after Deductible
Breastfeeding supplies and devices[9]	$0 Cost-Share	40% after Deductible
Lung cancer screening	$0 Cost-Share	40% after Deductible

Behavioral Health and Substance Abuse Services	In-Network (You Pay)	Out-of-Network (You Pay)
Inpatient Facility Services[4]	20% after Deductible	40% after Deductible
Inpatient Professional Services[4]	20% after Deductible	40% after Deductible
Outpatient therapy session	20% after Deductible	40% after Deductible
Outpatient services at a residential treatment facility	20% after Deductible	40% after Deductible
Prescription Drugs	**In-Network (You Pay)** **30 day Retail / 90 day Mail-Order**	**Out-of-Network (You Pay)**
Preventive Rx medications[10]	$0 Cost-Share (Preventive medications on the Humana Preventive Drug List have $0 cost-share, deductible does not apply), as long as they are filled at Optum Home Delivery or CenterWell Pharmacy retail locations. If they are filled at any other pharmacy, the cost-share for the network and non-network applies.	Contracted rate after the applicable copayment after out-of-network deductible[3]
Tobacco cessation medications (including OTC medications when prescribed by a physician)	$0 Cost-Share	Contracted rate after the applicable copayment after out-of-network deductible[3]
Tier 1 - Lower-cost generics and some brand name	$10 copay (Retail) / $20 copay (Mail-order) after deductible	Contracted rate after the applicable copayment after out-of-network deductible[3]
Tier 2 - Mid-range cost preferred brand name	$40 copay (Retail) / $80 copay (Mail-order) after deductible Formulary Tier 2 insulins can be obtained for NO Cost from any pharmacy	Contracted rate after the applicable copayment after out-of-network deductible[3]
Tier 3 - Higher cost brand name and some generics	$70 copay (Retail) / $140 copay (Mail-order) after deductible Formulary Tier 3 insulins can be obtained for $35, after deductible for a 30-day supply from any pharmacy; Formulary Tier E (excluded) insulins require a formulary override exception. If covered, the Tier 3 cost-share applies.	Contracted rate after the applicable copayment after out-of-network deductible[3]
Specialty (including self-administered specialty)	25% coinsurance after deductible Members are required to use Optum Specialty Pharmacy to fill specialty medications. If medication is filled at any other pharmacy, it is not covered.	Not Covered

*These services are mandated to be covered In-Network with no patient cost-sharing as they have received "A" or "B" gradings from the United States Preventive Services Task Force - they are subject to visit and diagnosis limitations.

[1]For coverage other than individual coverage, the family deductible applies; no individual deductible applies.

[2]For coverage other than individual coverage, the family out-of-pocket (MOOP) applies; no individual MOOP applies.

[3]Coinsurance /copayment (member amount) for out-of-network pharmacies does not apply to the maximum out-of-pocket limits.

[4]The Plan sometimes requires preauthorization for some services and procedures your physician or other provider may recommend for you. The Plan does this solely to determine whether the service or procedure qualifies payment under your benefit plan. You and your healthcare provider decide whether you should have such services or procedures. The Plan's preauthorization determination relates solely to payment by the Plan. To determine if a service or supply requires preauthorization for coverage, please visit member.accolade.com or call 1-844-467-3579. Failure to obtain necessary preauthorization when required may result in a reduction of otherwise payable benefits. If Preauthorization is required, your healthcare practitioner should call Provider Services to obtain preauthorization.

[5]Services received before or after the deductible is met will apply to the member's day/visit limit as specified by the given benefit.

[6]In-network and out-of-network expenses combine to the maximum benefit of $10,000 per covered person, per lifetime.

[7]In-network and out-of-network visit limits combine to a maximum of 12 visits per covered person, per plan year.

[8]Brand-name contraceptives are covered at 100% before deductible only when no generic alternative is available in that class or category.

[9]Breastfeeding supplies and devices must be purchased or rented from an in-network DME provider or qualified healthcare practitioner to be covered at 100% before deductible. The Plan does not cover breast pumps or supplies purchased at a retail store.

[10]Preventive Rx includes certain generic and preferred brand-name medications (without a generic equivalent) for diabetes and diabetic supplies, heart (blood pressure and cholesterol) and blood agents/thinners.

This document should not be used to guarantee coverage and payment for services rendered or to be rendered. Please refer to your Summary Plan Description or contact Accolade for the most up-to-date benefit information.