North Carolina

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Student Blue℠

Benefit Highlights for UNC Chapel Hill Postdocs | 2026-2027

Blue Options® benefit highlights (PPO)

Services	In-Network	Out-of-Network
All dollar amounts and percentages are what you, as a plan member, would pay.		
Campus Health Services (medical services)	No charge	Not applicable
Physician Office Visit Includes office surgery, consultation, X-rays, lab, and benefit period maximum of four office visits for the assessment of obesity in- and out-of-network.		
Primary Care Provider	20% after deductible	30% after deductible
Specialist	20% after deductible	30% after deductible
Preventive Care* Routine examinations, well-child care, immunizations, pap smears, mammograms, prostate specific antigen tests (PSAs). * Only federally- and state-mandated preventive services are available out-of-network, for which members will pay deductible and coinsurance, plus charges over the allowed amount. Visit BlueCrossNC.com/Preventive for more details.		
Primary Care Provider	No charge	30% after deductible
Specialist	No charge	30% after deductible
Therapies Short-term rehabilitative therapies (maximums apply to home, office, and outpatient settings) Physical/occupational: 30 visits per benefit period Speech therapy: 30 visits per benefit period		
Primary Care Provider	20% after deductible	30% after deductible
Specialist	20% after deductible	30% after deductible
Urgent Care Centers and Emergency Room		
Urgent care centers	20% after deductible	30% after deductible
Emergency room visit Copay waived and inpatient benefits apply if admitted. If held for observation, outpatient benefits apply.	$150 copayment, then 20% after deductible	$150 copayment, then 20% after deductible
Ambulatory Surgical Center	20% after deductible	30% after deductible
Inpatient and Outpatient Hospital Services		
Hospital and hospital-based services	20% after deductible	30% after deductible
Outpatient clinic services (other than Preventive Care above)	20% after deductible	30% after deductible
Professional services	20% after deductible	30% after deductible
Hospital and Professional		
Outpatient labs	20% after deductible	30% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests, such as EEGs and EKGs	20% after deductible	30% after deductible
CT scans, MRIs, MRAs, and PET scans in any location, including physician's office	20% after deductible	30% after deductible
Other Services		
Skilled Nursing Facility (60 days per benefit period)	20% after deductible	30% after deductible
Home Health Care, Durable Medical Equipment, and Hospice	20% after deductible	30% after deductible
Ambulance	20% after deductible	20% after deductible

Benefit highlights *(continued)*

Services	In-Network	Out-of-Network
All dollar amounts and percentages are what you, as a plan member, would pay.		
Maternity (includes prenatal and post-delivery care)		
Hospital services (delivery)	20% after deductible	30% after deductible
Professional services (delivery)	20% after deductible	30% after deductible
Transplants		
Hospital services	20% after deductible	30% after deductible
Professional services	20% after deductible	30% after deductible
Infertility Services		
Primary Care Provider	20% after deductible	30% after deductible
Specialist	20% after deductible	30% after deductible
Hospital services	20% after deductible	30% after deductible
Inpatient and outpatient professional services	20% after deductible	30% after deductible
Lifetime Maximum, Deductibles, and Out-of-Pocket Maximums The following deductibles and coinsurance maximums also apply to the services on the previous page and mental health and substance use services below.		
Lifetime benefit maximum	Unlimited	Unlimited
Deductibles		
Individual (per benefit period)	$500	$1,000
Family (per benefit period)	$1,500	$3,000
Out-of-Pocket Maximum		
Individual (per benefit period)	$2,100	$4,200
Family (per benefit period)	$6,300	$12,600
Mental Health and Substance Use Services Precertification required for inpatient and certain outpatient services.		
Mental Health Services		
Office visit	20% after deductible	30% after deductible
Inpatient/outpatient	20% after deductible	30% after deductible
Substance Use Services		
Office visit	20% after deductible	30% after deductible
Inpatient/outpatient	20% after deductible	30% after deductible
Prescription Drugs and Campus Health Services		
Generic or brand (30 day supply)	$10 copayment	Not applicable
Other Pharmacy Up to 30 day supply. 31-60 day supply is two copayments, and 61-90 day supply is three copayments. * There is $50 per drug minimum and $100 per drug maximum for each 30-day supply of Tier 5 drugs.	**Tier 1:** $20 copayment **Tier 2:** $35 copayment **Tier 3:** $50 copayment **Tier 4:** $75 copayment **Tier 5*:** 25% coinsurance	Copayment + charge over in-network allowed amount

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The benefit highlights is a summary of Blue Options 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 Blue Options benefit booklet from Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Customer Service.

Policy dates are 07/01/26 - 06/30/27

Important legal notices for students' Special Enrollment

Deductibles, coinsurance, limitations, and exclusions apply to this coverage. Further details of coverage, limitations, and exclusions will be provided in your benefit booklet.

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 cosmetic services or cosmetic surgery except as specifically covered by your health benefit plan
- 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 conception by artificial means
- For self-injectable drugs in the provider's office