Health Care Benefit Highlights

PPO 1500-70
(Blue Options SM)
$1,500 Individual Deductible
70% In-network Coinsurance

North Carolina Medical Society
Employee Benefit Plan

Sponsored by: **North Carolina Medical Society**
Marketed exclusively by: **SRA Benefits Consulting**
Administered by: **Blue Cross and Blue Shield of North Carolina**

Blue Options Benefit Highlights (PPO)

The amounts that appear on this benefit highlight 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, if applicable.*	**In-network**	**Out-of-network** [1]
Embedded Deductibles		
Individual (per Benefit Period)	$1,500	$3,000
Family (per Benefit Period)	$4,500	$9,000
Embedded Out-of-Pocket Limits		
Individual (per Benefit Period)	$5,000	$10,000
Family (per Benefit Period)	$10,000	$20,000
Benefit Maximums:		
Lifetime Total Dollar Maximum	Unlimited	Unlimited
Lifetime Infertility Benefit Maximum		
Ovulation Induction Cycles *(with or without insemination, per Member, in all places of service)*	3 Cycle Limits	
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 (combined)	30 visits	
Speech Therapy	30 visits	
Adaptive Behavior Treatment	Unlimited	
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 visits	
Nutritional Counseling Visits	Unlimited	
Physician Office Services *(See "Outpatient Services" for "outpatient clinic" or "hospital-based" services.)*		
Office Visits *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, Labs, and X-rays, unless otherwise specified.*		
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 Office-Based Services	0% no deductible	30% after deductible
Vendor Telehealth *Includes Telehealth services for medical/acute care/behavioral health*	$35 copayment	Benefits not available
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	0% no deductible	30% after deductible
Specialist	0% no deductible	30% after deductible

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Urgent and Emergency Care	In-network	Out-of-network [1]
Ambulance	30% after deductible	30% after deductible
Emergency Room Visit*	$750	$750
Urgent Care Centers Services	$75	$75

**If admitted to the hospital for inpatient or observation services your ER benefit will continue to apply until you are considered stable. 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.)		
Inpatient Hospital Facility Services	30% after deductible	50% after deductible
Inpatient Hospital Professional Services	30% after deductible	50% after deductible

Outpatient Services		
Hospital Based or Free-standing Facility Services *(other than preventive services above)*	30% after deductible	50% after deductible
Outpatient lab tests	30% after deductible	50% after deductible
Outpatient Mammography	0% no deductible	30% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEGs and EKGs	30% after deductible	50% after deductible
Mental Health and Substance Use Disorder Outpatient Services	30% after deductible	50% after deductible

Other Services		
Skilled Nursing Facility	30% after deductible	50% after deductible
Home Health Care and Hospice	30% after deductible	50% after deductible
Durable Medical Equipment, Medical Supplies, Orthotic Devices and Prosthetic Appliances	30% after deductible	50% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including a physician's office	30% after deductible	50% after deductible

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Prescription Drugs	**In-network**	**Out-of-network** [1]
Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bluecrossnc.com/preventive	0% no deductible	0% no deductible

Prescription Drug copayments, coinsurance* and deductibles* (*if applicable) apply to the Out-of-Pocket limit.*
Up to a 30-day supply is one copayment. A 31-60-day supply is two copayments. A 61-90-day supply is three copayments.

Essential 5 Tier Commercial Formulary, Broad Network. MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed).
Prior Plan approval, step therapy and quantity limits may apply.

Tier 1 Drugs	$10	$10
Tier 2 Drugs	$25	$25
Tier 3 Drugs	$40	$40
Tier 4 Drugs	$80	$80
Tier 5 Drugs	25%	25%

There a $100 per Prescription Maximum for each 30-day supply of Tier 5 drugs
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.

Lens and Frame Coverage*

Blue Cross NC will reimburse you up to the Benefit Period Maximum for glasses, hard, soft or disposable contact lenses.

Prescribed Eyeglasses Lens and Frame Benefit Period Maximum	$130 at 100%, then 90% thereafter

**Does not apply to the out-of-pocket limit*

[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

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
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!

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

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.

MAC B
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 DRUGS. 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 DRUGS, 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.htm] for a current list of these drugs; or 2) your PROVIDERS 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. NOTE: Penalty does not count towards out of pocket limit on MAC B plans.

Billing arrangement: ee, ee+spouse, ee+child, ee+children, fam