



*North Carolina Medical Society  
Employee Benefit Plan*

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## Health Care Benefit Highlights

*PPO 1-2-3 2500  
(Blue Options<sup>SM</sup>)  
\$2,500 Individual Deductible*

Sponsored by:  
North Carolina Medical Society

Marketed Exclusively by:  
MMIC Agency, LLC  
a Medical Mutual Group company

Administered by:  
Blue Cross and Blue Shield  
of North Carolina®

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# PPO 1-2-3<sup>SM</sup> Benefit Highlights

Level 1	In-network	Out-of-network <sup>1</sup>
<b>Routine Wellness Exams</b> (See outpatient clinic services-Level 3)		
<i>Includes routine physical exams, well baby, well-child care, immunizations, and lab tests and x-rays that are part of the preventive care service.</i>		
Primary Care Provider	100%	Not Available*
Specialist	100%	Not Available*
<b>Screening Services</b>		
<i>Includes gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammogram, and Prostate Specific Antigen Tests (PSAs)</i>		
Primary Care Provider	100%	70% after deductible
Specialist	100%	70% after deductible
<b>Screening Colonoscopy, When Performed Alone</b>	100%	70% after deductible
<i>Provided in any setting</i>		
<b>Screening Mammography, When Performed Alone</b>	100%	70% after deductible
<i>Provided in any setting</i>		
<b>Other Primary Care Office-based Services</b>		
<i>Includes consultations, second opinions, x-rays, lab tests and surgery. For these services provided by a specialist, see Level 3 Benefits.</i>		
Primary Care Provider	\$25 copayment	50% after deductible
<b>Routine Eye Exam</b>		
Specialist	100%	Not Available*
Level 2		
<b>Inpatient Hospital Services</b>		
<i>Includes Maternity, Delivery and Transplants</i>		
Hospital and Hospital Based Services	\$250 per admission copayment, then 80% after deductible	\$500 per admission copayment, then 50% after deductible
<b>Inpatient Professional Services</b>		
Specialist	80% after deductible	50% after deductible
<b>Skilled Nursing Facility</b> (60 days per Benefit Period)	80% after deductible	50% after deductible
<b>Inpatient Ambulance Services, Home Health Care, and Hospice Care</b>	80% after deductible	50% after deductible
<b>Inpatient Infertility Services</b>		
Hospital and Hospital Based Services	\$250 per admission copayment, then 80% after deductible	\$500 per admission copayment, then 50% after deductible
Specialist	80% after deductible	50% after deductible
<b>Inpatient Mental Health Facility Services*</b>		
Facility Mental Health Services	\$250 per admission copayment, then 80% after deductible	\$500 per admission copayment, then 50% after deductible
<b>Inpatient Mental Health Professional Services*</b>		
Specialist	80% after deductible	50% after deductible
<b>Inpatient Substance Abuse Services*</b>		
Facility Substance Abuse Services	\$250 per admission copayment, then 80% after deductible	\$500 per admission copayment, then 50% after deductible
<b>Inpatient Substance Abuse Professional Services*</b>		
Specialist	80% after deductible	50% after deductible

# PPO 1-2-3<sup>SM</sup> Benefit Highlights

Level 3	In-network	Out-of-network <sup>1</sup>
<b>Specialist Office-Based Services</b>		
Specialist	60% after deductible	50% after deductible
<b>Specialist Outpatient Facility-Based Services</b>		
Specialist	60% after deductible	50% after deductible
<b>Urgent Care Center Services</b>		60% after deductible
<b>Emergency Room Visit</b>		60% after deductible
<b>Outpatient Hospital Services</b>	60% after deductible	50% after deductible
<i>Includes hospital and hospital-based services, outpatient clinic services, surgery, outpatient ambulance, and outpatient diagnostic services such as lab tests, X-rays, ultrasounds, and other diagnostic tests, such as EEG's, EKG's, pulmonary function tests, short-term rehabilitative therapies and other therapies.</i>		
<b>Outpatient Labs and Mammograms with surgery or other services</b>	60% after deductible	50% after deductible
<b>Outpatient Labs and Colonoscopy with surgery or other services</b>	60% after deductible	50% after deductible
<b>Routine Wellness Exams and Screening Services provided in outpatient clinic setting (Primary Care or Specialist)</b>	100%	70% after deductible
<b>Therapies</b>		
<i>Short-Term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):</i>		
<i>Physical/Occupational/Chiropractic: 30 visits</i>		
<i>Speech Therapy: 30 visits</i>		
Specialist	60% after deductible	50% after deductible
Facility	60% after deductible	50% after deductible
<b>CT scans, MRI's, MRA's and PET scans in any location, including physician's office</b>	60% after deductible	50% after deductible
<b>Infertility Services</b>		
Outpatient Hospital and Ambulatory Surgery Center (ASC) Services	60% after deductible	50% after deductible
Outpatient Professional Services (Office, Outpatient Hospital, and ASC)	60% after deductible	50% after deductible
Specialist	60% after deductible	50% after deductible
<b>Mental Health Outpatient Facility Services*</b>		
Facility Mental Health Services	60% after deductible	50% after deductible
<b>Mental Health Outpatient Professional Services* (Office / Outpatient Facility)</b>		
Specialist	60% after deductible	50% after deductible
<b>Substance Abuse Outpatient Services (Office / Outpatient Facility)*</b>		
Facility Substance Abuse Services	60% after deductible	50% after deductible
<b>Prescription Drugs</b>		
<i>Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments. Infertility Drugs up to \$5,000 Lifetime Maximum.</i>		
<i>MAC C Pricing</i>		
Generic	\$10 copayment	Copayment + charge over In-network allowed amount
Tier 2 (Preferred Brand)	\$35 copayment	Copayment + charge over In-network allowed amount
Tier 3 (Brand)	\$50 copayment	Copayment + charge over In-network allowed amount

## PPO 1-2-3<sup>SM</sup> Benefit Highlights

Deductibles and Maximums	In-network	Out-of-network <sup>1</sup>
<b>Lifetime Benefit Maximum</b>	Unlimited	Unlimited
<b>Deductibles</b>		
Individual (per Benefit Period)	\$2,500	\$5,000
Family (per Benefit Period)	\$5,000	\$10,000
<b>Coinsurance Maximum</b>		
Individual (per Benefit Period)	\$5,000	\$10,000
Family (per Benefit Period)	\$10,000	\$20,000
<b>Infertility Services</b>		
Lifetime Maximum		\$5,000
<b>Mental Health and Substance Abuse Services</b>		
<i>*Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422.</i>		

Lens and Frame Coverage		
<i>BCBSNC will reimburse you up to the Benefit Period Maximum for glasses, hard, soft or disposable contact lenses.</i>		
Prescribed Eyeglass Lens and Frame Benefit Period Maximum		\$150

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 BCBNC and its members.

## ADDITIONAL INFORMATION

### 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. A charge shall be considered incurred on the date the service or supply was provided to a member.

### Allowed Amount

The charge that the Plan determines using a methodology that is applied to comparable providers for similar services under a similar health benefit plan.

### Coinsurance Maximum

The dollar amount of coinsurance a member must pay prior to the Plan paying 100% for certain services.

### Day and Visit Maximums

All day and visit maximums are on a combined In- and Out-of-Network basis.

### 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 and care management.

If you have a concern regarding the final determination of your care, you have the right to appeal the decision. If you would like a copy of a benefit booklet providing more information about our Utilization Management programs, call the toll free number listed in your information packet.

### 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, a penalty will be applied.

For maternity admissions, your provider is not required to obtain certification 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, if medically necessary.

All inpatient and outpatient Mental Health and Substance Abuse services must be certified in advance by Magellan Behavioral Health. Office visits do not require certification.

In-network providers are responsible for obtaining certifications. The member will bear no financial penalties if the in-network provider fails to obtain the appropriate authorization. The member is responsible for obtaining certification for services rendered by an out-of-network provider. Obtaining certification for Mental Health and Substance Abuse services is the member's responsibility. Failure to obtain certification for Mental Health and Substance Abuse services will result in these services being paid at the out-of-network benefit level.

### 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 a 24-hour health information service, a health topics library, asthma and diabetes management, a prenatal program and other health and wellness programs. You will also receive a quarterly health magazine and have access to online health and wellness information at [www.bcbssc.com](http://www.bcbssc.com). With this program you can get health advice anytime you need it, so you can learn how to 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
- 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 conception by artificial means

A waiting period for coverage of pre-existing conditions may apply to your coverage. The Plan defines pre-existing conditions as those conditions for which medical advice, diagnosis, care or treatment was received or recommended within 6 months of the date that your coverage begins. You may receive credit toward the 12-month waiting period if your enrollment date is within 63 days of the termination of your previous health coverage.

The benefit highlights is a summary of your 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.