Health Care Benefit Highlights

PPO 1-2-3 4000
(Blue Options SM)
$4,000 Individual Deductible

North Carolina Medical Society
Employee Benefit Plan

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

Blue Options 1-2-3[SM] Benefit Highlights (PPO)

The coinsurance amounts that appear on this benefit highlight represent Plan responsibility.

The coinsurance amounts that display in the benefit booklet represent member responsibility.

Level 1	In-network	Out-of-network[1]
Routine Wellness Exams (See hospital based clinics-Level 3)		
For the most updated list of general preventive/screenings, immunizations, well-baby/well-child care and women's preventive care services mandated under Federal law, see our website at bcbsnc.com/preventive.		
Routine eye exams are covered only In-Network as non-mandated Preventive Care.		
Nutritional counseling is covered and available In-Network and Out-of-Network.		
Primary Care Provider	100%, no deductible	Not Available
Specialist	100%, no deductible	Not Available
Screening Services		
**Colorectal screen, bone mass measurement, newborn hearing screening, prostate specific antigen tests (PSAs), gynecological exams, cervical cancer screening, ovarian cancer screening and mammograms are state mandated and also covered Out-of network.*		
Primary Care Provider	100%, no deductible	40% after deductible
Specialist	100%, no deductible	40% after deductible
Outpatient clinic	100%, no deductible	40% after deductible
	100%, no deductible	40% after deductible
Screening Colonoscopy, When Performed Alone	100%, no deductible	40% after deductible
Provided in any setting	100%, no deductible	
Screening Mammography, When Performed Alone		70% after deductible
Provided in any setting		
Other Primary Care Office-based Services		
Includes consultations, second opinions, x-rays, lab tests and surgery. For these services provided by a specialist, see Level 3 Benefits.		
Primary Care Provider & Telehealth	$35 copayment	40% after deductible
Mental Health & Substance Abuse	$35 copayment	40% after deductible
Level 2		
Inpatient Hospital Services		
Includes Maternity, Delivery and Transplants		
Hospital and Hospital Based Services	$250 per admission copayment, then 50%after deductible	$500 per admission copayment, then 40%after deductible
Inpatient Professional Services		
Specialist	70% after deductible	40% after deductible
Skilled Nursing Facility *(60 days per Benefit Period)*	70% after deductible	40% after deductible
Inpatient Home Health Care, and Hospice Care	70% after deductible	70% after deductible
Inpatient Ambulance Services	70% after deductible	40% after deductible
Inpatient Infertility Services		
Hospital and Hospital Based Services	$250 per admission copayment, then 70% after deductible	$500 per admission copayment, then 40% after deductible
Specialist	70% after deductible	40% after deductible
Inpatient Mental Health Facility Services		
Facility Mental Health Services	$250 per admission copayment, then 70% after deductible	$500 per admission copayment, then 40% after deductible
Inpatient Mental Health Professional Services		
Specialist	70% after deductible	40% after deductible
Inpatient Substance Abuse Services		
Facility Substance Abuse Services	$250 per admission copayment, then 70% after deductible	$500 per admission copayment, then 40% after deductible
Inpatient Substance Abuse Professional Services		
Specialist	70% after deductible	40% after deductible

Blue Options 1-2-3℠ Benefit Highlights (PPO)

Level 3	In-network	Out-of-network[1]
Specialist Office-Based Services		
Specialist	50% after deductible	40% after deductible
Specialist Outpatient Facility-Based Services		
Specialist	50% after deductible	40% after deductible
Urgent Care Center Services	50% after	
Emergency Room Visit	deductible 50% after deductible	
Outpatient Hospital Services	50% after deductible	40% after deductible
Includes hospital and hospital-based services, hospital based clinics, surgery, and outpatient diagnostic services such as lab tests, X-rays, ultrasounds, and other diagnostic tests, such as EEG's, EKG's, pulmonary function tests, rehabilitative, habilitative and other therapies.		
Outpatient Labs and Mammograms with surgery or other services	50% after deductible	40% after deductible
Outpatient Labs and Colonoscopy with surgery or other services	50% after deductible	40% after deductible
Routine Wellness Exams and Screening Services provided in outpatient clinic setting (Primary Care or Specialist)	100%, no deductible	70% after deductible
Outpatient Ambulance	50% after deductible	40% after deductible
Therapies		
Rehabilitative and Habilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):		
Physical/Occupational/Chiropractic: 30 visits		
Speech Therapy: 30 visits		
Specialist	50% after deductible	40% after deductible
Facility	50% after deductible	40% after deductible
CT scans, MRI's, MRA's and PET scans in any location, including physician's office	50% after deductible	40% after deductible
Infertility Services		
Outpatient Hospital and Ambulatory Surgery Center (ASC) Services	50% after deductible	40% after deductible
Outpatient Professional Services (Office, Outpatient Hospital, and ASC)	50% after deductible	40% after deductible
Specialist	50% after deductible	40% after deductible
Mental Health Outpatient Facility Services		
Facility Mental Health Services	50% after deductible	40% after deductible
Mental Health Outpatient Professional Services (Outpatient Facility)		
Specialist	50% afterdeductible	40% after deductible
Substance Abuse Outpatient Services (Outpatient Facility)		
Facility Substance Abuse Services	50% after deductible	40% after deductible

Prescription Drugs

Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments if received from a retail pharmacy, and 2.5 times the copayment if received from mail order. MAC B Pricing, Brand Penalty

Tier 1	$10 copayment	Copayment + charge over In-network allowed amount
Tier 2	$25 copayment	Copayment + charge over In-network allowed amount
Tier 3	$40 copayment	Copayment + charge over In-network allowed amount
Tier 4	$80 copayment	Copayment + charge over In-network allowed amount
Tier 5†	75% Coinsurance	Coinsurance + charge over In-network allowed amount
Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bcbsnc.com/preventive	100%, no deductible	100%, no deductible

† There is a $100 per Drug Maximum for each 30-day supply for Tier 5.

Blue Options 1-2-3[SM] Benefit Highlights (PPO)

Lifetime Maximum, Deductibles & Out-of-Pocket Limits	In-network	Out-of-network [1]
The following Deductibles and Out-of-Pocket limits apply to all services unless otherwise indicated:		
Lifetime Benefit Maximum	Unlimited	Unlimited
Deductibles		
Individual *(per Benefit Period)*	$4,000	$8,000
Family *(per Benefit Period)*	$8,000	$16,000
Out-of-Pocket Limits		
Individual *(per Benefit Period)*	$7,150	$14,300
Family *(per Benefit Period)*	$14,300	$28,600
Infertility Services		
Combined In-Network and Out-of-Network Lifetime Maximum of 3 ovulation induction cycles, with or without insemination, per Member for Infertility services, provided in all places of service.		

Lens and Frame Coverage*	
BCBSNC will reimburse you up to the Benefit Period Maximum for glasses, hard, soft or disposable contact lenses.	Covered up to $130, then 10%

*The PLAN will pay for either one pair of prescription eyeglasses, one pair of hard or soft contact lenses or one year supply of disposable contact lenses per BENEFIT PERIOD. Any services in excess of this BENEFIT PERIOD MAXIMUM are not COVERED SERVICES.

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 BCBSNC and its members.

ADDITIONAL INFORMATION ABOUT BLUE OPTIONS 1-2-3 FROM BCBSNC

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

Allowed Amount
The maximum amount that BCBSNC 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 BCBSNC 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.

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.

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 from BCBSNC 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 BCBSNC, if medically necessary.

All inpatient and certain outpatient Mental Health and Substance Abuse services must be certified in advance by Magellan Behavioral Health. Call Magellan Behavioral Health at 1-800-359-2422. 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 or out-of-state provider.

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 HealthLine Blue, our 24-hour health information service, a health topics library, asthma and diabetes management and a prenatal program. You will also have access to online health and wellness information at www.bcbsnc.com. With our 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, 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
- ☐ For reversal of sterilization
- ☐ For treatment of sexual dysfunction not related to organic disease
- ☐ For assisted reproductive technologies as defined by the Centers for Disease Control and Prevention
- ☐ For self-injectable drugs in the provider's office