

Health Care Benefit Highlights

PPO 2000-80

(Blue OptionsSM)

\$2,000 Individual Deductible

80% In-network Coinsurance



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**

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The coinsurance amounts that appear on this benefit highlight represent Plan responsibility. The coinsurance amounts that display in the benefit booklet 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.

Embedded Deductibles

	In-network	Out-of-network ¹
Individual (per Benefit Period)	\$2,000	\$4,000
Family (per Benefit Period)	\$6,000	\$12,000

Embedded Out-of-Pocket Limits

	In-network	Out-of-network ¹
Individual (per Benefit Period)	\$7,150	\$14,300
Family (per Benefit Period)	\$14,300	\$28,600

Benefit Maximums:

Lifetime Total Dollar Maximum

Unlimited

Lifetime Infertility Benefit Maximum

Ovulation Induction Cycles

3 Cycle Limits

(with insemination, per Member, in all places of service)

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.

Physical, Occupational and Chiropractic Therapies (combined)	30 visits
Speech Therapy	30 visits
Applied Behavioral Analysis (ABA) Therapy (ages 18 and younger)	\$40,000
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

Physician Office Services

(See "Outpatient Services" for "outpatient clinic" or "hospital-based" services.)

Office Visit

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, X-rays and Labs.

	In-network	Out-of-network ¹
Primary Care Provider	\$35	70% after deductible
Specialist	\$70	70% after deductible
Mental Health and Substance Use Disorder	100% no deductible	70% after deductible

Vendor Telehealth

\$35 copayment

Includes Telehealth services for medical/acute care/behavioral health/telephone

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.

	In-network	Out-of-network ¹
Primary Care Provider	100% no deductible	70% after deductible
Specialist	100% no deductible	70% after deductible

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Urgent and Emergency Care

	In-network	Out-of-network ¹
Ambulance	80% after deductible	80% after deductible
Emergency Room Visit*	\$500	\$500
Urgent Care Centers	\$75	\$75

**If admitted from the ER, any applicable ER member responsibility does not apply; instead, Inpatient Hospital benefits apply. If held for observation, Outpatient benefits apply. See "Inpatient Hospital Services" and "Outpatient Services". 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	80% after deductible	70% after deductible
Inpatient Hospital Professional Services	80% after deductible	70% after deductible

Outpatient Services

Hospital Based or Free-standing Facility Services <i>(other than preventive services above)</i>	80% after deductible	70% after deductible
Outpatient Diagnostic Services		
Outpatient lab tests	100% no deductible	70% after deductible
Outpatient Mammography	100% no deductible	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEGs and EKGs	80% after deductible	70% after deductible

Other Services

Skilled Nursing Facility	80% after deductible	70% after deductible
Home Health Care and Hospice	80% after deductible	70% after deductible
Durable Medical Equipment, Prosthetics and Orthotics	80% after deductible	70% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including a physician's office	80% after deductible	70% after deductible

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Prescription Drugs

Preventive OTC Medications and Contraceptive

In-network
100% no deductible

Out-of-network¹
100% no deductible

Drugs and Devices as listed at bluecrossnc.com/preventive

Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments.

Prescription Drug copayments*, coinsurance* and deductibles* (*if applicable) apply to the Out-of-Pocket limit.

MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed).

Penalty does not count toward OOP Limit. Enhanced 5 Tier Commercial, Broad Network Formulary.

Prior Plan approval, step therapy and quantity limits may apply.

All pharmacy copay and/or coinsurance amounts below apply after the medical deductible is satisfied.

Tier 1 Drugs	\$10	\$10
Tier 2 Drugs	\$25	\$25
Tier 3 Drugs	\$40	\$40
Tier 4 Drugs	\$80	\$80
Tier 5 Drugs	75%	75%

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

Covered up to \$130, then 10%

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

*

*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 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

Because we want to help you stay healthy, we offer a variety of wellness benefits and services. You can take advantage of the Health Line BlueSM, our 24-hour free nurse support line, a health topics library, chronic condition management and a prenatal program. You will also have access to online health and wellness tools and trackers at BlueConnectNC.com. With our program you can get health advice anytime you need it, so you can learn how to take charge of your health.

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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 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

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.

Plan codes: PN08018 RN04621 MPN0812 SPN0722 C003400 VN00009 D000100
Facets codes: MED-_____ DRU-_____ VIS-_____
Billing arrangement: ee, ee+child, ee+children, ee+spouse, ee+spouse+child, fam