

Health Care Benefit Highlights

*PPO 7900
(Blue OptionsSM)
\$7,900 Individual Deductible
100% 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	In-network	Out-of-network ¹
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The following Deductibles, Out-of-Pocket Limits, and Benefit Maximums apply to all services. All copays are before deductible.

Embedded Deductibles

Individual (per Benefit Period)	\$7,900	\$15,800
Family (per Benefit Period)	\$15,800	\$31,600

Embedded Out-of-Pocket Limits

Individual (per Benefit Period)	\$7,900	\$17,100
Family (per Benefit Period)	\$15,800	\$34,200

Benefit Maximums:

Lifetime Total Dollar Maximum	Unlimited	Unlimited
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Lifetime Infertility Benefit Maximum

Ovulation Induction Cycles <i>(with or without insemination, per Member, in all places of service)</i>	3 Cycle Limits
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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
Adaptive Behavior Treatment is covered for members, up to age 19.	\$40,000
Skilled Nursing Facility Stay	60 days
Provider Office visits for the evaluation and treatment of obesity <i>(maximum does not apply to dietician/nutritional visits)</i>	4 visits
Nutritional Counseling	Unlimited

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.

Primary Care Provider	0% after deductible	30% after deductible
Specialist	0% after deductible	30% after deductible
Mental Health and Substance Use Disorder	0% after deductible	30% after deductible

Vendor Telehealth

0% after deductible	Benefits not available
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Includes Telehealth services for medical/acute care/behavioral health

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	0% after deductible	0% after deductible
Emergency Room Visit*	0% after deductible	0% after deductible
Urgent Care Centers	0% after deductible	0% after deductible

*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.) You may receive a better benefit if you receive care at a Blue Distinction Center (BDC). Visit bluecrossnc.com/bdc to find a BDC.

Inpatient Hospital Facility Services	0% after deductible	30% after deductible
Inpatient Hospital Professional Services	0% after deductible	30% after deductible

Outpatient Services

Hospital Based or Free-standing Facility Services (other than preventive services above)	0% after deductible	30% after deductible
Outpatient Diagnostic Services		
Outpatient lab tests	0% no deductible	30% after deductible
Preventive Mammography	0% no deductible	30% after deductible
Diagnostic Mammography	0% after deductible	30% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEGs and EKGs	0% after deductible	30% after deductible

Other Services

Skilled Nursing Facility	0% after deductible	30% after deductible
Home Health Care and Hospice	0% after deductible	30% after deductible
Durable Medical Equipment, Prosthetics and Orthotics	0% after deductible	30% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including a physician's office	0% after deductible	30% after deductible

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Prescription Drugs

Preventive OTC Medications and Contraceptive
Drugs and Devices as listed at bluecrossnc.com/preventive

In-network
0% no deductible

Out-of-network¹
0% no deductible

Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is 2.5 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. Essential 5 Tier Commercial, Broad Network Formulary.

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

Tier 1 Drugs	\$20	\$20
Tier 2 Drugs	\$35	\$35
Tier 3 Drugs	\$45	\$45
Tier 4 Drugs	\$90	\$90
Tier 5 Drugs	25%	25%

There is a \$200 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.

¹NOTICE: 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.

Lens and Frame Coverage*

Covered up to \$130, then 10%

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

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

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 Blue, 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
- Weight Loss Drugs

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.

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