



North Carolina Medical Society Employee Benefit Plan

Health Care Benefit Highlights

*PPO 500-80
(Blue OptionsSM)
\$500 Individual Deductible
80% In-network Coinsurance*

Sponsored by:
North Carolina Medical Society

Marketed Exclusively by:
MMIC Agency, Inc.
a Medical Mutual company

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

PPO 500-80

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

In-network**Out-of-network¹****Office Visit**

Includes Office Surgery, Consultation, X-rays, Lab and benefit period maximum of 4 office visits for the assessment of obesity in and out of network.

Primary Care Provider
Specialist

\$20 copayment
\$40 copayment

70% after deductible
70% after deductible

Preventive Care

Routine Examinations, Well-Child Care, Immunizations, Pap Smears, Mammograms, Prostate Specific Antigen Tests (PSAs)

Primary Care Provider
Specialist

\$20 copayment
\$40 copayment

Not Available*
Not Available*

**Pap Smears, Mammograms and PSAs are covered Out-of-network.*

Therapies

Short-Term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):

Physical/Occupational: 30 Visits per Benefit Period

Speech Therapy: 30 Visits per Benefit Period

Primary Care Provider
Specialist

\$20 copayment
\$40 copayment

70% after deductible
70% after deductible

Urgent Care Centers and Emergency Room

Urgent Care Centers
Emergency Room Visit (*Inpatient Hospital benefits apply if admitted. If held for Observation, Outpatient benefits apply. See "Inpatient and Outpatient Hospital Services". Copayment waived if admitted*)

\$50 copayment
\$150 copayment

\$50 copayment
\$150 copayment

Ambulatory Surgical Center

80% after deductible

70% after deductible

Inpatient and Outpatient Hospital Services

Hospital and Hospital Based Services
Outpatient Clinic Services
Professional Services
Hospital and Professional
Outpatient Labs and Mammograms with surgery or other services
Outpatient Labs and Mammograms without surgery or other services
Inpatient Diagnostic services including X-rays, CT scans and MRIs
*Outpatient Diagnostic services including X-rays, CT scans and MRIs
**Only applies if single service*

80% after deductible
80% after deductible
80% after deductible
80% after deductible
80% after deductible
100%
80% after deductible
80% no deductible

70% after deductible
70% after deductible
70% after deductible
70% after deductible
70% after deductible
70% after deductible
70% after deductible
70% no deductible

Other Services

Skilled Nursing Facility (*60 Days per Benefit Period*)

80% after deductible

70% after deductible

Home Health Care, Ambulance,

80% after deductible

70% after deductible

Durable Medical Equipment and Hospice

Maternity

Maternity Delivery includes Prenatal and Post-delivery care

Hospital Services (Delivery)
Professional Services (Delivery)

80% after deductible
80% after deductible

70% after deductible
70% after deductible

Transplants

Hospital Services
Professional Services

80% after deductible
80% after deductible

70% after deductible
70% after deductible

Infertility and Sexual Dysfunction Services

Up to \$5,000 per Lifetime

Primary Care Provider
Specialist

\$20 copayment
\$40 copayment

70% after deductible
70% after deductible

Hospital Services
Inpatient and Outpatient Professional Services

80% after deductible
80% after deductible

70% after deductible
70% after deductible

Vision Care

Comprehensive Eye Exam
Lens and Frame Discount*
Disposable Contact Lens Discount*

\$20 copayment
30%
15%

Benefits not available
Benefits not available
Benefits not available

**Discounts apply only if purchased from BCBSNC participating providers who own optical dispensaries.*

PPO 500-80**Lifetime Maximum, Deductibles & Coinsurance Maximums****In-network****Out-of-network¹**

The following Deductibles and Coinsurance Maximums apply to the services on the previous page and Mental Health and Substance Abuse services below:

Lifetime Benefit Maximum

Unlimited

Unlimited

Deductibles

Individual (per Benefit Period)

\$500

\$1,000

Family (per Benefit Period)

\$1,500

\$3,000

Coinsurance Maximum

Individual (per Benefit Period)

\$3,000

\$6,000

Family (per Benefit Period)

\$9,000

\$18,000

Mental Health and Substance Abuse Services**Certified*****Non-Certified¹**

*Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-379-2422.

Mental Health Services

Office (30 visits per Benefit Period)

\$40 copayment

70% after deductible

Inpatient/Outpatient (30 days per Benefit Period)

80% after deductible

70% after deductible

(Certain mental health conditions do not have visit limits. For a list of these conditions, refer to your benefit booklet.)

Substance Abuse Services

Office Visit

\$40 copayment

70% after deductible

Inpatient/Outpatient

80% after deductible

70% after deductible

Benefit Period Maximum

\$8,000

Lifetime Maximum

\$16,000

Prescription Drugs

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.

MAC C Pricing.

Tier 1 (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

Lens and Frame Coverage

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

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 BCBSNC 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. 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. You may preview the benefit booklet by requesting a copy of your benefit booklet from Customer Services.