

# North Carolina Medical Society Employee Benefit Plan

Plan Selection	PPO Plan 1		PPO Plan 2		PPO Plan 3		PPO Plan 4		PPO Plan 5	
	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network	Network	Non-Network
Annual Deductible	\$500/ \$1500	\$1000/ \$3000	\$750/ \$2250	\$1500/ \$4500	\$1000/ \$3000	\$2000/ \$6000	\$1500/ \$4500	\$3000/ \$9000	\$2000/ \$6000	\$4000/ \$12000
Coinsurance Maximum Out of Pocket	\$3000/ \$9000	\$6000/ \$18000	\$3000/ \$9000	\$6000/ \$18000	\$3000/ \$9000	\$6000/ \$18000	\$4000/ \$12000	\$8000/ \$24000	\$4500/ \$13500	\$9000/ \$27000
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit * (Primary/Specialist)	\$20/\$30	70% After Ded	\$20/\$30	70% After Ded	\$20/30	70% After Ded	\$20/\$30	70% After Ded	\$25/\$50	70% After Ded
Maternity Care	80% After Ded	70% After Ded	80% After Ded	70% After Ded	80% After Ded	70% After Ded	80% After Ded	70% After Ded	80% After Ded	70% After Ded
Urgent Care	\$30	\$30	\$30	\$30	\$30	\$30	\$30	\$30	\$50	\$50
Emergency Room	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100	\$100
Hospital – Inpatient	80% After Ded	70% After Ded	80% After Ded	70% After Ded	80% After Ded	70% After Ded	80% After Ded	70% After Ded	80% After Ded	70% After Ded
Hospital – Outpatient	80% After Ded	70% After Ded	80% After Ded	70% After Ded	80% After Ded	70% After Ded	80% After Ded	70% After Ded	80% After Ded	70% After Ded
Mental Health Services: Office Visits Inpatient/Outpatient	\$30 80%	70% 70%	\$30 80%	70% 70%	\$30 80%	70% 70%	\$30 80%	70% 70%	\$50 80%	70% 70%
Substance Abuse Services: Office Visit Inpatient/Outpatient	\$30 80%	70% 70%	\$30 80%	70% 70%	\$30 80%	70% 70%	\$30 80%	70% 70%	\$50 80%	70% 70%
Vision Examination Lens & Frames Discount Disposable Contact Lens Discount Lens & Frame Coverage	\$20 30%	N/A N/A	\$20 30%	N/A N/A	\$20 30%	N/A N/A	\$20 30%	N/A N/A	\$25 30%	N/A N/A
Prescription Drugs	\$10/25/40	Copay + charge over In- network allowed amount	\$10/25/40	Copay + charge over In- network allowed amount	\$10/35/50	Copay + charge over In- network allowed amount	\$10/25/40	Copay + charge over In- network allowed amount	\$10/35/50	Copay + charge over In- network allowed amount

\*Preventive Care Services: Routine Examinations, Well-Child Care and Immunizations must be provided by a Network provider. Pap Smears, Mammograms and Prostate Specific Antigen Tests (PSAs) are covered Out-of-network.