BlueCross BlueShield of North Carolina

North Carolina Retail Merchants Association

Effective January 1, 2025

Blue Options with HSA Fund

Prepared By

WILLIAM H HARTSFIELD JR

Prospect # 418336
Combo # 459756

The benefit highlight is a summary of Blue Options benefits. This is meant only to be a summary. You will also be receiving a Summary of Benefits and Coverage document (referred to as an SBC) required under Health Care Reform. Both documents are provided as a convenience to compare available health plan coverage options. Final interpretation of the Blue Options health plan 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 the Blue Options benefit booklet from Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Customer Service.

To the best of our knowledge, Blue Cross NC believes that this plan meets Massachusetts' Minimum Creditable Coverage standards for 2025. However, you should verify with your own legal counsel that this plan meets your needs.

The plan is intended to be a high deductible health plan (HDHP) that qualifies its members to contribute to a health savings account (HSA), unless its members are otherwise ineligible under applicable federal requirements. Please consult a qualified tax advisor if you are unsure about whether or not you are ineligible. In addition, the DEDUCTIBLE and OUT-OF-POCKET LIMIT amounts listed in the Summary of Benefits may be revised each year in accordance with Internal Revenue Service (IRS) rulings.

Blue Options with HSA Fund Benefit Highlights (PPO)

The amounts that appear on this benefit highlight 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, if applicable.*	**In-network**	**Out-of-network** [1]
Aggregate Deductibles		
Individual (per Benefit Period)	$2,500	$5,000
Family Member (per Benefit Period)	$5,000	$10,000
Family Total (per Benefit Period)	$5,000	$10,000
Aggregate Out-of-Pocket Limits		
Individual (per Benefit Period)	$5,000	$10,000
Family Member (per Benefit Period)	$7,000	$14,000
Family Total (per Benefit Period)	$10,000	$20,000
Benefit Maximums:		
Lifetime Total Dollar Maximum	Unlimited	Unlimited
Lifetime Infertility Benefit Maximum		
Ovulation Induction Cycles *(with or without insemination, per Member, in all places of service)*	3 Cycle Limits	
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. There are no limits on therapy and nutritional counseling visits related to mental illness diagnoses.*		
Physical, Occupational and Chiropractic Therapies (combined)	30 visits	
Speech Therapy	30 visits	
Adaptive Behavior Treatment	Unlimited	
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 visits	
Nutritional Counseling	30 visits	
Physician Office Services *(See "Outpatient Services" for "outpatient clinic" or "hospital-based" services.)*		
Office Visits *Includes all Office Visits regardless of specialty or diagnosis (including medical, infertility, therapies and pre-natal/post-delivery care unable to be included in the global delivery fee). Includes Office Surgery, Consultation, Labs, and X-rays, unless otherwise specified.*		
Primary Care Provider	20% after deductible	50% after deductible
Specialist	20% after deductible	50% after deductible
Mental Health and Substance Use Disorder Office-Based Services	20% after deductible	50% after deductible
Vendor Telehealth *Includes Telehealth services for primary care, acute care, mental health teletherapy, dermatology, and nutritional counseling.*	0% after deductible	Benefits not available
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

Blue Options with HSA Fund Benefit Highlights (PPO)

Urgent and Emergency Care	In-network	Out-of-network [1]
Ambulance Services	20% after deductible	20% after deductible
Emergency Room Visit* (with or without Observation)	20% after deductible	20% after deductible
Emergency Room Visit* (with Inpatient Admission)	20% after deductible	20% after deductible
Urgent Care Services	20% after deductible	50% after deductible

**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.) If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. Depending on your plan, you may reduce your coinsurance by 10% simply by utilizing an inpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Inpatient Hospital Facility Services	20% after deductible	50% after deductible
Inpatient Hospital Professional Services	20% after deductible	50% after deductible

Outpatient Services		
If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. Depending on your plan, you may reduce your coinsurance by 10% simply by utilizing an outpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Hospital Based or Free-standing Facility Services *(other than preventive services above)*	20% after deductible	50% after deductible
Outpatient lab tests	20% after deductible	50% 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	20% after deductible	50% after deductible
Mental Health and Substance Use Disorder Outpatient Services	20% after deductible	50% after deductible

Other Services		
Skilled Nursing Facility	20% after deductible	50% after deductible
Home Health Care and Hospice	20% after deductible	50% after deductible
Durable Medical Equipment, Medical Supplies, Orthotic Devices and Prosthetic Appliances	20% after deductible	50% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including a physician's office	20% after deductible	50% after deductible

Blue Options with HSA Fund Benefit Highlights (PPO)

Prescription Drugs	**In-network**	**Out-of-network** [1]
Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bluecrossnc.com/preventive	0% no deductible	0% no deductible

All pharmacy coinsurance amounts below apply after the medical deductible is satisfied, and apply to the medical Out-of-Pocket limit.

Essential 5 Tier Commercial Formulary, Broad Network. MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed).
Prior Plan approval, step therapy and quantity limits may apply.

Prescription drugs	20% after deductible
Enhanced Preventive Drugs	20% no deductible

Any drugs from the Enhanced Preventive Drug List prescribed for a preventive purpose is covered at 20% no deductible.

Diabetic Supplies obtained at the pharmacy will apply to a drug tier. Check your benefit booklet for additional details

You are responsible for charges over the allowed amount received from an Out-of-Network pharmacy, and those amounts are not included in the Deductible or Out-of-Pocket limit.

Limits apply to Infertility drugs, refer to your benefit booklet.

[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 with HSA Fund

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
Your benefits provide access to a variety of wellness programs and services to help you stay healthy. These include nurse support for chronic conditions, pregnancy and behavioral health, as well as tobacco cessation programs and exclusive member discounts on things like gym memberships, glasses, hearing aids and more. You can also access a wide selection of online and digital health and wellness tools and resources at bluecrossnc.com to help you take charge of your health!

Health Savings Account
This plan, with an HSA Fund, is not a Health Savings Account (HSA), but it instead is a health insurance plan intended to be paired with an HSA. The HSA is provided to you directly by a separate HSA Administrator. An HSA is a savings vehicle for medical care expenses. It helps to pay the expenses that insurance does not pay. Individuals and employers can contribute money into an HSA on a tax-deductible or pre-tax basis for individuals. If used to pay for qualified health care expenses, your HSA account's growth and use is tax-free. In addition, HSAs roll over from year to year and are fully portable if an individual changes jobs. HSAs can only be opened by and contributed to on behalf of individuals who are covered under a qualified High Deductible Health Plan (HDHP). For more information on your HSA eligibility if you have other, additional health coverage, consult your tax advisor.

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 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

Aggregate Deductible Definition
If you selected Employee Only Coverage, the Employee Deductible and Out-Of-Pocket Limit will apply. If you selected Family Coverage, either the Family Member or Family Total Deductible and Out-of-Pocket Limit will apply. All covered family members contribute to the same Family Total Deductible and the same Family Total Out-of-Pocket Limit, however any individual Family Member who reaches his or her Family Member Deductible and Out-Of-Pocket Limit will have the benefit levels for each apply to them only, and not the entire Family. The Family Total Deductible and Out-Of-Pocket Limit must be met before the respective benefit levels for each are payable for all Family Members, regardless of whether each individual Family Member's Deductible and Out-Of-Pocket Limit has been met.

MAC B
When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND-NAME PRESCRIPTION DRUG, your cost may be higher.

Please note: You may pay a different amount in certain situations when choosing between GENERIC and BRAND-NAME PRESCRIPTION DRUGS. If you decide you want the BRAND-NAME drug on the higher tier instead of the GENERIC equivalent on the lower tier, you will pay the BRAND-NAME copayment or coinsurance plus the cost difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT. For PRESCRIPTION DRUGS received from an OUT-OF-NETWORK pharmacy, you will also pay any charges over the ALLOWED AMOUNT.

You may not be required to pay the difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT for certain BRAND-NAME PRESCRIPTION DRUGS, if these criteria are met: 1) the BRAND-NAME PRESCRIPTION DRUG is on the Narrow Therapeutic Index (NTI). See [ncbop.org/faqs/Pharmacist/faq_NTIDrugs.htm] for a current list of these drugs; or 2) your PROVIDERS has required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts may still apply.

From time to time, MEMBERS may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce PRESCRIPTION DRUG costs. NOTE: Penalty does not count towards out of pocket limit on MAC B plans.

BlueCross BlueShield of North Carolina

North Carolina Retail Merchants Association

Effective January 1, 2025

Blue Options 1-2-3

Prepared By

WILLIAM H HARTSFIELD JR

Prospect # 418336
Quote # 6442594

The benefit highlight is a summary of Blue Options 1-2-3 benefits. This is meant only to be a summary. You will also be receiving a Summary of Benefits and Coverage document (referred to as an SBC) required under Health Care Reform. Both documents are provided as a convenience to compare available health plan coverage options. Final interpretation of the Blue Options 1-2-3 health plan 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 the Blue Options 1-2-3 benefit booklet from Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Customer Service.

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

The amounts that appear on this benefit highlight 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, if applicable.*	**In-network**	**Out-of-network** [1]
Embedded Deductibles		
Individual (per Benefit Period)	$5,000	$10,000
Family (per Benefit Period)	$10,000	$20,000
Embedded Out-of-Pocket Limits		
Individual (per Benefit Period)	$9,200	$18,400
Family (per Benefit Period)	$18,400	$36,800
Benefit Maximums:		
Lifetime Total Dollar Maximum	Unlimited	Unlimited
Lifetime Infertility Benefit Maximum		
Ovulation Induction Cycles *(with or without insemination, per Member, in all places of service)*	3 Cycle Limits	
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. There are no limits on therapy and nutritional counseling visits related to mental illness diagnoses.*		
Physical, Occupational and Chiropractic Therapies (combined)	30 visits	
Speech Therapy	30 visits	
Adaptive Behavior Treatment	Unlimited	
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 visits	
Nutritional Counseling	30 visits	

Level 1	**In-network**	**Out-of-network** [1]
Preventive Care (See hospital based clinics-Level 3) (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
Primary Care Office-based Services *Includes all Office Visits regardless of diagnosis (including medical, therapies and pre-natal/post-delivery care unable to be included in the global delivery fee). Includes Office Surgery, Consultation, and X-rays. For these services provided by a specialist, including a Behavioral Health provider, see Level 3 Benefits.*		
Primary Care Provider	$35	60% after deductible
Log in to Blue Connect to select your Primary Care Provider (PCP). Your copay is waived for your first 3 visits to your selected PCP.		
Vendor Telehealth Vendor Telehealth Includes Telehealth services for Primary Care, Acute Care, Mental Health Teletherapy, Dermatology, and Nutritional Counseling.	No Charge	Benefits not available

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

Level 2	In-network	Out-of-network [1]
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.)If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. You may reduce your coinsurance by 10% simply by utilizing an inpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Inpatient Admission Copay	$250 per admission, then	$500 per admission, then
Hospital and Hospital Based Services	30% after deductible	60% after deductible
Inpatient Professional Services		
Professional Services	30% after deductible	60% after deductible
Skilled Nursing Facility	30% after deductible	60% after deductible
Inpatient Home Health Care and Hospice Care	30% after deductible	60% after deductible
Emergency Room Visit* (with Inpatient Admission)	30% after deductible	
*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.		

Level 3	In-network	Out-of-network [1]
Specialist Office-Based Services		
Professional Services	50% after deductible	60% after deductible
Specialist Outpatient Facility-Based Service		
Professional Services	50% after deductible	60% after deductible
Mental Health and Substance Use Disorder Office-Based Services	50% after deductible	60% after deductible
Mental Health and Substance Use Disorder Outpatient Services	50% after deductible	60% after deductible
Ambulance Services	50% after deductible	50% after deductible
Urgent Care Services	$100	$200
Emergency Room Visit* (with or without Observation)	50% after deductible	
*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.		
Outpatient Hospital Services	50% after deductible	60% 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 EEGs, EKGs, pulmonary function tests, rehabilitative, habilitative and other therapies.		
If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. You may reduce your coinsurance by 10% simply by utilizing an outpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Outpatient Diagnostic Services		
Outpatient lab tests	50% after deductible	60% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including physician's office, Durable Medical Equipment, Home Infusion Therapy, Medical Supplies, Orthotic Devices and Prosthetic Appliances	50% after deductible	60% after deductible

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

Prescription Drugs	**In-network**	**Out-of-network** [1]
Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bluecrossnc.com/preventive	0% no deductible	0% no deductible

Prescription Drug copayments, coinsurance* and deductibles* (*if applicable) apply to the Out-of-Pocket limit.*
Up to a 30-day supply is one copayment. A 31-60-day supply is two copayments. A 61-90-day supply is three copayments.

Essential 5 Tier Commercial Formulary, Broad Network. MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed).
Prior Plan approval, step therapy and quantity limits may apply.

Tier 1 Drugs	$15	$15
Tier 2 Drugs	$45	$45
Tier 3 Drugs	$85	$85
Tier 4 Drugs	$105	$105
Tier 5 Drugs	25%	25%

Diabetic Supplies obtained at the pharmacy will apply to a drug tier. Check your benefit booklet for additional details.
There is a $50 per Prescription Minimum and a $200 per Prescription Maximum for each 30-day supply of Tier 5 drugs.
Any Out-of-Network charges over the allowed amount are not included in this maximum.

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.

[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 1-2-3

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
Your benefits provide access to a variety of wellness programs and services to help you stay healthy. These include nurse support for chronic conditions, pregnancy and behavioral health, as well as tobacco cessation programs and exclusive member discounts on things like gym memberships, glasses, hearing aids and more. You can also access a wide selection of online and digital health and wellness tools and resources at bluecrossnc.com to help you 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, or as specifically covered by your health benefit plan
- For reversal of sterilization
- 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.

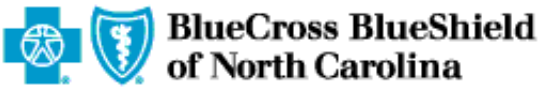
MAC B
When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND-NAME PRESCRIPTION DRUG, your cost may be higher.

Please note: You may pay a different amount in certain situations when choosing between GENERIC and BRAND-NAME PRESCRIPTION DRUGS. If you decide you want the BRAND-NAME drug on the higher tier instead of the GENERIC equivalent on the lower tier, you will pay the BRAND-NAME copayment or coinsurance plus the cost difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT. For PRESCRIPTION DRUGS received from an OUT-OF-NETWORK pharmacy, you will also pay any charges over the ALLOWED AMOUNT.

You may not be required to pay the difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT for certain BRAND-NAME PRESCRIPTION DRUGS, if these criteria are met: 1) the BRAND-NAME PRESCRIPTION DRUG is on the Narrow Therapeutic Index (NTI). See [ncbop.org/faqs/Pharmacist/faq_NTIDrugs.htm] for a current list of these drugs; or 2) your PROVIDERS has required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts may still apply.

From time to time, MEMBERS may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce PRESCRIPTION DRUG costs. NOTE: Penalty does not count towards out of pocket limit on MAC B plans.

Plan codes: PT70827 R063738 MTI1900 STI1900 C000100
Facets codes: MED-FS008925 (base) DRU-BR003188 (base)
Billing arrangement: ee, ee+spouse, ee+children, fam



North Carolina Retail Merchants Association

Effective January 1, 2025

Blue Options All Copay

Prepared By

WILLIAM H HARTSFIELD JR

Prospect # 418336
Quote # 6442599

The benefit highlight is a summary of Blue Options All Copay benefits. This is meant only to be a summary. You will also be receiving a Summary of Benefits and Coverage document (referred to as an SBC) required under Health Care Reform. Both documents are provided as a convenience to compare available health plan coverage options. Final interpretation of the Blue Options All Copay health plan 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 the Blue Options All Copay benefit booklet from Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Customer Service.

To the best of our knowledge, Blue Cross NC believes that this plan meets Massachusetts' Minimum Creditable Coverage standards for 2025. However, you should verify with your own legal counsel that this plan meets your needs.

Blue Options All Copay Benefit Highlights (PPO)

The amounts that appear on this benefit highlight represent Member responsibility.

	In-network	Out-of-network [1]
Deductibles, Out-of-Pocket Limits, Copayments Levels & Benefit Maximums		
The following Deductibles and Out-of-Pocket Limits apply to all services. All copays are before deductible, if applicable.		
Embedded Deductibles		
Individual (per Benefit Period)	$0	$250
Family (per Benefit Period)	$0	$500
Embedded Out-of-Pocket Limits		
Individual (per Benefit Period)	$3,500	$7,000
Family (per Benefit Period)	$7,000	$14,000
Copayment Levels [2]		
Preventive and Other Services	$0	50% after deductible
Primary Care, Labs, and Other Services	$20	50% after deductible
Specialist, Sinus Surgeries, Urgent Care, and Other Services	$40	50%** after deductible
Ambulance, Imaging and Other Services	$250	50%** after deductible
Emergency Room Visit (with or without Observation) and Other Services	$500	$500
Outpatient Facility	$750	50% after deductible
Inpatient Facility and Emergency Room Visit (with Inpatient Admission)	$2,000	50% after deductible

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. There are no limits on therapy and nutritional counseling visits related to mental illness diagnoses.

Physical, Occupational and Chiropractic Therapies (combined)	30 visits
Speech Therapy	30 visits
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 visits
Nutritional Counseling Visits	30 visits

Benefit Maximums:

Lifetime Total Dollar Maximum	Unlimited
Lifetime Infertility Benefit Maximum	
Ovulation Induction Cycles (with or without insemination, per Member, in all places of service)	3 cycles

	In-network	Out-of-network [1]
Prescription Drugs		
Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bluecrossnc.com/preventive	$0	$0

Prescription Drug copayments*, coinsurance* and deductibles* (*if applicable) apply to the Out-of-Pocket limit.
Up to a 30-day supply is one copayment. A 31-60-day supply is two copayments. A 61-90-day supply is three copayments.
Essential 5 Tier Commercial Formulary, Broad Network, MAC B Pricing (Brand Penalty when Generic Equivalent is available, and Provider does not require Brand to be dispensed). Prior Plan approval, step therapy and quantity limits may apply.

Tier 1 Drugs	$15	$15
Tier 2 Drugs	$30	$30
Tier 3 Drugs	$45	$45
Tier 4 Drugs	$85	$85
Tier 5 Drugs	$200	$200

Diabetic Supplies obtained at the pharmacy will apply to a drug tier. Check your benefit booklet for additional details.
Any Out-of-Network charges over the allowed amount are not included in this maximum.
You are responsible for charges over the allowed amount received from an out-of-network pharmacy.
Limits apply to infertility drugs, refer to your benefits booklet.

Blue Options All Copay Benefit Highlights (PPO)

	In-network	Out-of-network [1]
Preventive Care and Other Services	**$0**	**30% after deductible**
Preventive Care		
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.		
Inpatient and Outpatient Professional Services (See below for Professional Anesthesia Services)		
Preventive and Diagnostic Mammography		
Hospice Care		
Vendor Telehealth Includes Telehealth services for Primary Care, Acute Care, Mental Health Teletherapy, Dermatology, and Nutritional Counseling.		
Primary Care, Labs, and Other Services	**$20**	**50% after deductible**
Primary Care Office Visits		
Log in to Blue Connect to select your Primary Care Provider (PCP). Your copay is waived for your first 3 visits to your selected PCP.		
Lab tests (In any location, including physician's office)		
Mental Health and Substance Use Disorder Office-Based Services		
Specialist, Sinus Surgeries, Urgent Care, and Other Services	**$40**	**50%** after deductible**
Specialist Office Visits		
Urgent Care Services		$80
Professional Anesthesia Services (In any location)		
Durable Medical Equipment Prosthetic Appliances and Orthotics		
Home Health Care		
Outpatient X-Rays, Ultrasounds, EEG and EKG		
Skilled Nursing Facility (Per day)		
Therapies		
Occupational, Physical, Chiropractic, Speech, Cardiac, Radiation, Chemotherapy, Dialysis. All places of service, except Inpatient.		
Ambulance, Imaging and Other Services	**$250**	**50%** after deductible**
Ambulance Services		$250
CT Scans, MRIs, MRAs and PET Scans (In any location, including physician's office)		
Emergency Room Visit (with or without Observation) and Other Services	**$500**	**$500**
Emergency Room Visit(with or without Observation)		
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.		
Outpatient Facility	**$750**	**50% after deductible**
Outpatient Hospital Facility Services		
Inpatient Facility and Emergency Room Visit (with Inpatient Admission)	**$2,000**	**50% after deductible**
Inpatient Hospital Facility Services (Per admission)		
If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. Depending on your plan, you may save $250 in an outpatient setting or $500 in an inpatient setting via a copayment reduction simply by utilizing an outpatient or inpatient Blue Distinction Center. Please visit bluecrossnc.com/bdc for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Emergency Room Visit (with Inpatient Admission)		
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.		

[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.

[2]The highest copay, per provider, per date of service, per claim will apply. If rendered services are billed by more than one provider, multiple copays will apply.

**Unless otherwise specified.

ADDITIONAL INFORMATION ABOUT BLUE OPTIONS ALL COPAY

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
Your benefits provide access to a variety of wellness programs and services to help you stay healthy. These include nurse support for chronic conditions, pregnancy and behavioral health, as well as tobacco cessation programs and exclusive member discounts on things like gym memberships, glasses, hearing aids and more. You can also access a wide selection of online and digital health and wellness tools and resources at bluecrossnc.com to help you 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.

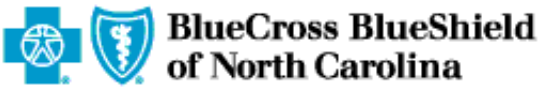
Your health benefit plan does not cover services, supplies, drugs or charges that are:

- 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 adult routine eye exams
- 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
- For treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- For reversal of sterilization

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.

MAC B
When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND-NAME PRESCRIPTION DRUG, your cost may be higher. Please note: You may pay a different amount in certain situations when choosing between GENERIC and BRAND-NAME PRESCRIPTION DRUGS. If you decide you want the BRAND-NAME drug on the higher tier instead of the GENERIC equivalent on the lower tier, you will pay the BRAND-NAME copayment or coinsurance plus the cost difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT. For PRESCRIPTION DRUGS received from an OUT-OF-NETWORK pharmacy, you will also pay any charges over the ALLOWED AMOUNT. You may not be required to pay the difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT for certain BRAND-NAME PRESCRIPTION DRUGS, if these criteria are met: 1) the BRAND-NAME PRESCRIPTION DRUG is on the Narrow Therapeutic Index (NTI). See [ncbop.org/faqs/Pharmacist/faq_NTIDrugs.htm] for a current list of these drugs; or 2) your PROVIDERS has required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts may still apply. From time to time, MEMBERS may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce PRESCRIPTION DRUG costs.

Plan codes: PY00018 R070029 MC00014 SC00014 C003100
Facets codes: MED-FS009740 (base) DRU-BR003479 (base)
Billing arrangement: ee, ee+spouse, ee+children, fam



North Carolina Retail Merchants Association

Effective January 1, 2025

Blue Options All Copay

Prepared By

WILLIAM H HARTSFIELD JR

Prospect # 418336
Quote # 6442600

The benefit highlight is a summary of Blue Options All Copay benefits. This is meant only to be a summary. You will also be receiving a Summary of Benefits and Coverage document (referred to as an SBC) required under Health Care Reform. Both documents are provided as a convenience to compare available health plan coverage options. Final interpretation of the Blue Options All Copay health plan 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 the Blue Options All Copay benefit booklet from Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Customer Service.

To the best of our knowledge, Blue Cross NC believes that this plan meets Massachusetts' Minimum Creditable Coverage standards for 2025. However, you should verify with your own legal counsel that this plan meets your needs.

Blue Options All Copay Benefit Highlights (PPO)

The amounts that appear on this benefit highlight represent Member responsibility.

	In-network	Out-of-network [1]
Deductibles, Out-of-Pocket Limits, Copayments Levels & Benefit Maximums		
The following Deductibles and Out-of-Pocket Limits apply to all services. All copays are before deductible, if applicable.		
Embedded Deductibles		
Individual (per Benefit Period)	$0	$250
Family (per Benefit Period)	$0	$500
Embedded Out-of-Pocket Limits		
Individual (per Benefit Period)	$9,200	$18,400
Family (per Benefit Period)	$18,400	$36,800
Copayment Levels [2]		
Preventive and Other Services	$0	50% after deductible
Primary Care, Labs, and Other Services	$50	50% after deductible
Specialist, Sinus Surgeries, Urgent Care, and Other Services	$100	50%** after deductible
Ambulance, Imaging and Other Services	$650	50%** after deductible
Emergency Room Visit (with or without Observation) and Other Services	$1,500	$1,500
Outpatient Facility	$2,000	50% after deductible
Inpatient Facility and Emergency Room Visit (with Inpatient Admission)	$7,500	50% after deductible

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. There are no limits on therapy and nutritional counseling visits related to mental illness diagnoses.

Physical, Occupational and Chiropractic Therapies (combined)	30 visits
Speech Therapy	30 visits
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 visits
Nutritional Counseling Visits	30 visits

Benefit Maximums:

Lifetime Total Dollar Maximum	Unlimited
Lifetime Infertility Benefit Maximum	
Ovulation Induction Cycles (with or without insemination, per Member, in all places of service)	3 cycles

	In-network	Out-of-network [1]
Prescription Drugs		
Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bluecrossnc.com/preventive	$0	$0

Prescription Drug copayments*, coinsurance* and deductibles* (*if applicable) apply to the Out-of-Pocket limit.
Up to a 30-day supply is one copayment. A 31-60-day supply is two copayments. A 61-90-day supply is three copayments.
Essential 5 Tier Commercial Formulary, Broad Network, MAC B Pricing (Brand Penalty when Generic Equivalent is available, and Provider does not require Brand to be dispensed). Prior Plan approval, step therapy and quantity limits may apply.

Tier 1 Drugs	$15	$15
Tier 2 Drugs	$30	$30
Tier 3 Drugs	$45	$45
Tier 4 Drugs	$85	$85
Tier 5 Drugs	$200	$200

Diabetic Supplies obtained at the pharmacy will apply to a drug tier. Check your benefit booklet for additional details.
Any Out-of-Network charges over the allowed amount are not included in this maximum.
You are responsible for charges over the allowed amount received from an out-of-network pharmacy.
Limits apply to infertility drugs, refer to your benefits booklet.

Blue Options All Copay Benefit Highlights (PPO)

	In-network	Out-of-network [1]
Preventive Care and Other Services	**$0**	**30% after deductible**
Preventive Care		
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.		
Inpatient and Outpatient Professional Services (See below for Professional Anesthesia Services)		
Preventive and Diagnostic Mammography		
Hospice Care		
Vendor Telehealth Includes Telehealth services for Primary Care, Acute Care, Mental Health Teletherapy, Dermatology, and Nutritional Counseling.		
Primary Care, Labs, and Other Services	**$50**	**50% after deductible**
Primary Care Office Visits		
Log in to Blue Connect to select your Primary Care Provider (PCP). Your copay is waived for your first 3 visits to your selected PCP.		
Lab tests (In any location, including physician's office)		
Mental Health and Substance Use Disorder Office-Based Services		
Specialist, Sinus Surgeries, Urgent Care, and Other Services	**$100**	**50%** after deductible**
Specialist Office Visits		
Urgent Care Services		$200
Professional Anesthesia Services (In any location)		
Durable Medical Equipment Prosthetic Appliances and Orthotics		
Home Health Care		
Outpatient X-Rays, Ultrasounds, EEG and EKG		
Skilled Nursing Facility (Per day)		
Therapies		
Occupational, Physical, Chiropractic, Speech, Cardiac, Radiation, Chemotherapy, Dialysis. All places of service, except Inpatient.		
Ambulance, Imaging and Other Services	**$650**	**50%** after deductible**
Ambulance Services		$650
CT Scans, MRIs, MRAs and PET Scans (In any location, including physician's office)		
Emergency Room Visit (with or without Observation) and Other Services	**$1,500**	**$1,500**
Emergency Room Visit(with or without Observation)		
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.		
Outpatient Facility	**$2,000**	**50% after deductible**
Outpatient Hospital Facility Services		
Inpatient Facility and Emergency Room Visit (with Inpatient Admission)	**$7,500**	**50% after deductible**
Inpatient Hospital Facility Services (Per admission)		
If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. Depending on your plan, you may save $250 in an outpatient setting or $500 in an inpatient setting via a copayment reduction simply by utilizing an outpatient or inpatient Blue Distinction Center. Please visit bluecrossnc.com/bdc for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Emergency Room Visit (with Inpatient Admission)		
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.		

[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.

[2]The highest copay, per provider, per date of service, per claim will apply. If rendered services are billed by more than one provider, multiple copays will apply.

**Unless otherwise specified.

ADDITIONAL INFORMATION ABOUT BLUE OPTIONS ALL COPAY

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
Your benefits provide access to a variety of wellness programs and services to help you stay healthy. These include nurse support for chronic conditions, pregnancy and behavioral health, as well as tobacco cessation programs and exclusive member discounts on things like gym memberships, glasses, hearing aids and more. You can also access a wide selection of online and digital health and wellness tools and resources at bluecrossnc.com to help you 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 adult routine eye exams
- 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
- For treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- For reversal of sterilization

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.

MAC B
When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND-NAME PRESCRIPTION DRUG, your cost may be higher. Please note: You may pay a different amount in certain situations when choosing between GENERIC and BRAND-NAME PRESCRIPTION DRUGS. If you decide you want the BRAND-NAME drug on the higher tier instead of the GENERIC equivalent on the lower tier, you will pay the BRAND-NAME copayment or coinsurance plus the cost difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT. For PRESCRIPTION DRUGS received from an OUT-OF-NETWORK pharmacy, you will also pay any charges over the ALLOWED AMOUNT. You may not be required to pay the difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT for certain BRAND-NAME PRESCRIPTION DRUGS, if these criteria are met: 1) the BRAND-NAME PRESCRIPTION DRUG is on the Narrow Therapeutic Index (NTI). See [ncbop.org/faqs/Pharmacist/faq_NTIDrugs.htm] for a current list of these drugs; or 2) your PROVIDERS has required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts may still apply. From time to time, MEMBERS may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce PRESCRIPTION DRUG costs.

Plan codes: PY00022 R070029 MC00018 SC00018 C006900
Facets codes: MED-FS009744 (base) DRU-BR003479 (base)
Billing arrangement: ee, ee+spouse, ee+children, fam

BlueCross BlueShield of North Carolina

North Carolina Retail Merchants Association

Effective January 1, 2025

Blue Options

Prepared By

WILLIAM H HARTSFIELD JR

Prospect # 418336
Quote # 6442601

The benefit highlight is a summary of Blue Options benefits. This is meant only to be a summary. You will also be receiving a Summary of Benefits and Coverage document (referred to as an SBC) required under Health Care Reform. Both documents are provided as a convenience to compare available health plan coverage options. Final interpretation of the Blue Options health plan 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 the Blue Options benefit booklet from Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Customer Service.

To the best of our knowledge, Blue Cross NC believes that this plan meets Massachusetts' Minimum Creditable Coverage standards for 2025. However, you should verify with your own legal counsel that this plan meets your needs.

Blue Options Benefit Highlights (PPO)

The amounts that appear on this benefit highlight 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, if applicable.*	**In-network**	**Out-of-network** [1]
Embedded Deductibles		
Individual (per Benefit Period)	$2,000	$4,000
Family Total (per Benefit Period)	$4,000	$8,000
Embedded Out-of-Pocket Limits		
Individual (per Benefit Period)	$4,000	$8,000
Family Total (per Benefit Period)	$8,000	$16,000
Benefit Maximums:		
Lifetime Total Dollar Maximum	Unlimited	Unlimited
Lifetime Infertility Benefit Maximum		
Ovulation Induction Cycles *(with or without insemination, per Member, in all places of service)*	3 Cycle Limits	
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. There are no limits on therapy and nutritional counseling visits related to mental illness diagnoses.*		
Physical, Occupational and Chiropractic Therapies (combined)	30 visits	
Speech Therapy	30 visits	
Adaptive Behavior Treatment	Unlimited	
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 visits	
Nutritional Counseling	30 visits	
Physician Office Services *(See "Outpatient Services" for "outpatient clinic" or "hospital-based" services.)*		
Office Visits *Includes all Office Visits regardless of specialty or diagnosis (including medical, infertility, therapies and pre-natal/post-delivery care unable to be included in the global delivery fee). Includes Office Surgery, Consultation, Labs, and X-rays, unless otherwise specified.*		
Primary Care Provider	$25	50% after deductible
Log in to Blue Connect to select your Primary Care Provider (PCP). Your copay is waived for your first 3 visits to your selected PCP.		
Specialist	$50	50% after deductible
Mental Health and Substance Use Disorder Office-Based Services	20% after deductible	50% after deductible
Vendor Telehealth *Includes Telehealth services for primary care, acute care, mental health teletherapy, dermatology, and nutritional counseling.*	No Charge	Benefits not available
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

Blue Options Benefit Highlights (PPO)

Urgent and Emergency Care	In-network	Out-of-network [1]
Ambulance Services	20% after deductible	20% after deductible
Emergency Room Visit* (with or without Observation)	$300	$300
Emergency Room Visit* (with Inpatient Admission)	20% after deductible	20% after deductible
Urgent Care Services	$50	$100

**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.) If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. Depending on your plan, you may reduce your coinsurance by 10% simply by utilizing an inpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Inpatient Hospital Facility Services	20% after deductible	50% after deductible
Inpatient Hospital Professional Services	20% after deductible	50% after deductible

Outpatient Services		
If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. Depending on your plan, you may reduce your coinsurance by 10% simply by utilizing an outpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Hospital Based or Free-standing Facility Services *(other than preventive services above)*	20% after deductible	50% after deductible
Outpatient lab tests	20% after deductible	50% after deductible
Outpatient Mammography	0% no deductible	30% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEGs and EKGs	20% after deductible	50% after deductible
Mental Health and Substance Use Disorder Outpatient Services	20% after deductible	50% after deductible

Other Services		
Skilled Nursing Facility	20% after deductible	50% after deductible
Home Health Care and Hospice	20% after deductible	50% after deductible
Durable Medical Equipment, Medical Supplies, Orthotic Devices and Prosthetic Appliances	20% after deductible	50% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including a physician's office	20% after deductible	50% after deductible

Blue Options Benefit Highlights (PPO)

Prescription Drugs	**In-network**	**Out-of-network** [1]
Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bluecrossnc.com/preventive	0% no deductible	0% no deductible

Prescription Drug copayments, coinsurance* and deductibles* (*if applicable) apply to the Out-of-Pocket limit.*
Up to a 30-day supply is one copayment. A 31-60-day supply is two copayments. A 61-90-day supply is three copayments.

Essential 5 Tier Commercial Formulary, Broad Network. MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed).
Prior Plan approval, step therapy and quantity limits may apply.

Tier 1 Drugs	$15	$15
Tier 2 Drugs	$45	$45
Tier 3 Drugs	$85	$85
Tier 4 Drugs	$105	$105
Tier 5 Drugs	25%	25%

Diabetic Supplies obtained at the pharmacy will apply to a drug tier. Check your benefit booklet for additional details
There is a $50 per Prescription Minimum and a $200 per Prescription Maximum for each 30-day supply of Tier 5 drugs.
Any Out-of-Network charges over the allowed amount are not included in this maximum.

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.

[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
Your benefits provide access to a variety of wellness programs and services to help you stay healthy. These include nurse support for chronic conditions, pregnancy and behavioral health, as well as tobacco cessation programs and exclusive member discounts on things like gym memberships, glasses, hearing aids and more. You can also access a wide selection of online and digital health and wellness tools and resources at bluecrossnc.com to help you 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, or as specifically covered by your health benefit plan
- For reversal of sterilization
- 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.

MAC B
When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND-NAME PRESCRIPTION DRUG, your cost may be higher.

Please note: You may pay a different amount in certain situations when choosing between GENERIC and BRAND-NAME PRESCRIPTION DRUGS. If you decide you want the BRAND-NAME drug on the higher tier instead of the GENERIC equivalent on the lower tier, you will pay the BRAND-NAME copayment or coinsurance plus the cost difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT. For PRESCRIPTION DRUGS received from an OUT-OF-NETWORK pharmacy, you will also pay any charges over the ALLOWED AMOUNT.

You may not be required to pay the difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT for certain BRAND-NAME PRESCRIPTION DRUGS, if these criteria are met: 1) the BRAND-NAME PRESCRIPTION DRUG is on the Narrow Therapeutic Index (NTI). See [ncbop.org/faqs/Pharmacist/faq_NTIDrugs.htm] for a current list of these drugs; or 2) your PROVIDERS has required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts may still apply.

From time to time, MEMBERS may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce PRESCRIPTION DRUG costs. NOTE: Penalty does not count towards out of pocket limit on MAC B plans.

Plan codes: PB93251 R063738 MP99960 SP99960 C003300
Facets codes: MED-FS009376 (base) DRU-BR003188 (base)
Billing arrangement: ee, ee+spouse, ee+children, fam

BlueCross BlueShield of North Carolina

North Carolina Retail Merchants Association

Effective January 1, 2025

Blue Options

Prepared By

WILLIAM H HARTSFIELD JR

Prospect # 418336
Quote # 6442595

The benefit highlight is a summary of Blue Options benefits. This is meant only to be a summary. You will also be receiving a Summary of Benefits and Coverage document (referred to as an SBC) required under Health Care Reform. Both documents are provided as a convenience to compare available health plan coverage options. Final interpretation of the Blue Options health plan 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 the Blue Options benefit booklet from Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Customer Service.

Blue Options Benefit Highlights (PPO)

The amounts that appear on this benefit highlight 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, if applicable.*	**In-network**	**Out-of-network** [1]
Embedded Deductibles		
Individual (per Benefit Period)	$3,000	$6,000
Family Total (per Benefit Period)	$6,000	$12,000
Embedded Out-of-Pocket Limits		
Individual (per Benefit Period)	$6,000	$12,000
Family Total (per Benefit Period)	$12,000	$24,000
Benefit Maximums:		
Lifetime Total Dollar Maximum	Unlimited	Unlimited
Lifetime Infertility Benefit Maximum		
Ovulation Induction Cycles *(with or without insemination, per Member, in all places of service)*	3 Cycle Limits	
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. There are no limits on therapy and nutritional counseling visits related to mental illness diagnoses.*		
Physical, Occupational and Chiropractic Therapies (combined)	30 visits	
Speech Therapy	30 visits	
Adaptive Behavior Treatment	Unlimited	
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 visits	
Nutritional Counseling	30 visits	
Physician Office Services *(See "Outpatient Services" for "outpatient clinic" or "hospital-based" services.)*		
Office Visits *Includes all Office Visits regardless of specialty or diagnosis (including medical, infertility, therapies and pre-natal/post-delivery care unable to be included in the global delivery fee). Includes Office Surgery, Consultation, Labs, and X-rays, unless otherwise specified.*		
Primary Care Provider	$35	60% after deductible
Log in to Blue Connect to select your Primary Care Provider (PCP). Your copay is waived for your first 3 visits to your selected PCP.		
Specialist	$70	60% after deductible
Mental Health and Substance Use Disorder Office-Based Services	30% after deductible	60% after deductible
Vendor Telehealth *Includes Telehealth services for primary care, acute care, mental health teletherapy, dermatology, and nutritional counseling.*	No Charge	Benefits not available
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

Blue Options Benefit Highlights (PPO)

Urgent and Emergency Care	In-network	Out-of-network [1]
Ambulance Services	30% after deductible	30% after deductible
Emergency Room Visit* (with or without Observation)	$500	$500
Emergency Room Visit* (with Inpatient Admission)	30% after deductible	30% after deductible
Urgent Care Services	$70	$140

**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.) If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. Depending on your plan, you may reduce your coinsurance by 10% simply by utilizing an inpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Inpatient Hospital Facility Services	30% after deductible	60% after deductible
Inpatient Hospital Professional Services	30% after deductible	60% after deductible

Outpatient Services		
If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. Depending on your plan, you may reduce your coinsurance by 10% simply by utilizing an outpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Hospital Based or Free-standing Facility Services *(other than preventive services above)*	30% after deductible	60% after deductible
Outpatient lab tests	30% after deductible	60% after deductible
Outpatient Mammography	0% no deductible	30% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEGs and EKGs	30% after deductible	60% after deductible
Mental Health and Substance Use Disorder Outpatient Services	30% after deductible	60% after deductible

Other Services		
Skilled Nursing Facility	30% after deductible	60% after deductible
Home Health Care and Hospice	30% after deductible	60% after deductible
Durable Medical Equipment, Medical Supplies, Orthotic Devices and Prosthetic Appliances	30% after deductible	60% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including a physician's office	30% after deductible	60% after deductible

Blue Options Benefit Highlights (PPO)

Prescription Drugs	**In-network**	**Out-of-network** [1]
Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bluecrossnc.com/preventive	0% no deductible	0% no deductible

Prescription Drug copayments, coinsurance* and deductibles* (*if applicable) apply to the Out-of-Pocket limit.*
Up to a 30-day supply is one copayment. A 31-60-day supply is two copayments. A 61-90-day supply is three copayments.

Essential 5 Tier Commercial Formulary, Broad Network. MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed).
Prior Plan approval, step therapy and quantity limits may apply.

Tier 1 Drugs	$15	$15
Tier 2 Drugs	$45	$45
Tier 3 Drugs	$85	$85
Tier 4 Drugs	$105	$105
Tier 5 Drugs	25%	25%

Diabetic Supplies obtained at the pharmacy will apply to a drug tier. Check your benefit booklet for additional details
There is a $50 per Prescription Minimum and a $200 per Prescription Maximum for each 30-day supply of Tier 5 drugs.
Any Out-of-Network charges over the allowed amount are not included in this maximum.

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.

[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
Your benefits provide access to a variety of wellness programs and services to help you stay healthy. These include nurse support for chronic conditions, pregnancy and behavioral health, as well as tobacco cessation programs and exclusive member discounts on things like gym memberships, glasses, hearing aids and more. You can also access a wide selection of online and digital health and wellness tools and resources at bluecrossnc.com to help you 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, or as specifically covered by your health benefit plan
- For reversal of sterilization
- 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.

MAC B
When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND-NAME PRESCRIPTION DRUG, your cost may be higher.

Please note: You may pay a different amount in certain situations when choosing between GENERIC and BRAND-NAME PRESCRIPTION DRUGS. If you decide you want the BRAND-NAME drug on the higher tier instead of the GENERIC equivalent on the lower tier, you will pay the BRAND-NAME copayment or coinsurance plus the cost difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT. For PRESCRIPTION DRUGS received from an OUT-OF-NETWORK pharmacy, you will also pay any charges over the ALLOWED AMOUNT.

You may not be required to pay the difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT for certain BRAND-NAME PRESCRIPTION DRUGS, if these criteria are met: 1) the BRAND-NAME PRESCRIPTION DRUG is on the Narrow Therapeutic Index (NTI). See [ncbop.org/faqs/Pharmacist/faq_NTIDrugs.htm] for a current list of these drugs; or 2) your PROVIDERS has required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts may still apply.

From time to time, MEMBERS may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce PRESCRIPTION DRUG costs. NOTE: Penalty does not count towards out of pocket limit on MAC B plans.

Plan codes: PB93164 R063738 MP90002 SP90002 C003400
Facets codes: MED-FS009157 (base) DRU-BR003188 (base)
Billing arrangement: ee, ee+spouse, ee+children, fam

BlueCross BlueShield of North Carolina

North Carolina Retail Merchants Association

Effective January 1, 2025

Blue Options 1-2-3

Prepared By

WILLIAM H HARTSFIELD JR

Prospect # 418336
Quote # 6442596

The benefit highlight is a summary of Blue Options 1-2-3 benefits. This is meant only to be a summary. You will also be receiving a Summary of Benefits and Coverage document (referred to as an SBC) required under Health Care Reform. Both documents are provided as a convenience to compare available health plan coverage options. Final interpretation of the Blue Options 1-2-3 health plan 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 the Blue Options 1-2-3 benefit booklet from Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Customer Service.

To the best of our knowledge, Blue Cross NC believes that this plan meets Massachusetts' Minimum Creditable Coverage standards for 2025. However, you should verify with your own legal counsel that this plan meets your needs.

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

The amounts that appear on this benefit highlight 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, if applicable.*	**In-network**	**Out-of-network** [1]
Embedded Deductibles		
Individual (per Benefit Period)	$2,000	$4,000
Family (per Benefit Period)	$4,000	$8,000
Embedded Out-of-Pocket Limits		
Individual (per Benefit Period)	$4,000	$8,000
Family (per Benefit Period)	$8,000	$16,000
Benefit Maximums:		
Lifetime Total Dollar Maximum	Unlimited	Unlimited
Lifetime Infertility Benefit Maximum		
Ovulation Induction Cycles *(with or without insemination, per Member, in all places of service)*	3 Cycle Limits	
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. There are no limits on therapy and nutritional counseling visits related to mental illness diagnoses.*		
Physical, Occupational and Chiropractic Therapies (combined)	30 visits	
Speech Therapy	30 visits	
Adaptive Behavior Treatment	Unlimited	
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 visits	
Nutritional Counseling	30 visits	

Level 1	**In-network**	**Out-of-network** [1]
Preventive Care (See hospital based clinics-Level 3) (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
Primary Care Office-based Services *Includes all Office Visits regardless of diagnosis (including medical, therapies and pre-natal/post-delivery care unable to be included in the global delivery fee). Includes Office Surgery, Consultation, and X-rays. For these services provided by a specialist, including a Behavioral Health provider, see Level 3 Benefits.*		
Primary Care Provider	$25	40% after deductible
Log in to Blue Connect to select your Primary Care Provider (PCP). Your copay is waived for your first 3 visits to your selected PCP.		
Vendor Telehealth	No Charge	Benefits not available
Vendor Telehealth Includes Telehealth services for Primary Care, Acute Care, Mental Health Teletherapy, Dermatology, and Nutritional Counseling.		

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

Level 2	In-network	Out-of-network [1]
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.)If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. You may reduce your coinsurance by 10% simply by utilizing an inpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Inpatient Admission Copay	$250 per admission, then	$500 per admission, then
Hospital and Hospital Based Services	10% after deductible	40% after deductible
Inpatient Professional Services		
Professional Services	10% after deductible	40% after deductible
Skilled Nursing Facility	10% after deductible	40% after deductible
Inpatient Home Health Care and Hospice Care	10% after deductible	40% after deductible
Emergency Room Visit* (with Inpatient Admission)	10% after deductible	
*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.		

Level 3	In-network	Out-of-network [1]
Specialist Office-Based Services		
Professional Services	30% after deductible	40% after deductible
Specialist Outpatient Facility-Based Service		
Professional Services	30% after deductible	40% after deductible
Mental Health and Substance Use Disorder Office-Based Services	30% after deductible	40% after deductible
Mental Health and Substance Use Disorder Outpatient Services	30% after deductible	40% after deductible
Ambulance Services	30% after deductible	30% after deductible
Urgent Care Services	$100	$200
Emergency Room Visit* (with or without Observation)	30% after deductible	
*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.		
Outpatient Hospital Services	30% 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 EEGs, EKGs, pulmonary function tests, rehabilitative, habilitative and other therapies.		
If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. You may reduce your coinsurance by 10% simply by utilizing an outpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Outpatient Diagnostic Services		
Outpatient lab tests	30% after deductible	40% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including physician's office, Durable Medical Equipment, Home Infusion Therapy, Medical Supplies, Orthotic Devices and Prosthetic Appliances	30% after deductible	40% after deductible

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

Prescription Drugs	**In-network**	**Out-of-network** [1]
Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bluecrossnc.com/preventive	0% no deductible	0% no deductible

Prescription Drug copayments, coinsurance* and deductibles* (*if applicable) apply to the Out-of-Pocket limit.*
Up to a 30-day supply is one copayment. A 31-60-day supply is two copayments. A 61-90-day supply is three copayments.

Essential 5 Tier Commercial Formulary, Broad Network. MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed).
Prior Plan approval, step therapy and quantity limits may apply.

Tier 1 Drugs	$15	$15
Tier 2 Drugs	$45	$45
Tier 3 Drugs	$85	$85
Tier 4 Drugs	$105	$105
Tier 5 Drugs	25%	25%

Diabetic Supplies obtained at the pharmacy will apply to a drug tier. Check your benefit booklet for additional details.
There is a $50 per Prescription Minimum and a $200 per Prescription Maximum for each 30-day supply of Tier 5 drugs.
Any Out-of-Network charges over the allowed amount are not included in this maximum.

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.

[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 1-2-3

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
Your benefits provide access to a variety of wellness programs and services to help you stay healthy. These include nurse support for chronic conditions, pregnancy and behavioral health, as well as tobacco cessation programs and exclusive member discounts on things like gym memberships, glasses, hearing aids and more. You can also access a wide selection of online and digital health and wellness tools and resources at bluecrossnc.com to help you 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, or as specifically covered by your health benefit plan
- For reversal of sterilization
- 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.

MAC B
When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND-NAME PRESCRIPTION DRUG, your cost may be higher.

Please note: You may pay a different amount in certain situations when choosing between GENERIC and BRAND-NAME PRESCRIPTION DRUGS. If you decide you want the BRAND-NAME drug on the higher tier instead of the GENERIC equivalent on the lower tier, you will pay the BRAND-NAME copayment or coinsurance plus the cost difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT. For PRESCRIPTION DRUGS received from an OUT-OF-NETWORK pharmacy, you will also pay any charges over the ALLOWED AMOUNT.

You may not be required to pay the difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT for certain BRAND-NAME PRESCRIPTION DRUGS, if these criteria are met: 1) the BRAND-NAME PRESCRIPTION DRUG is on the Narrow Therapeutic Index (NTI). See [ncbop.org/faqs/Pharmacist/faq_NTIDrugs.htm] for a current list of these drugs; or 2) your PROVIDERS has required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts may still apply.

From time to time, MEMBERS may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce PRESCRIPTION DRUG costs. NOTE: Penalty does not count towards out of pocket limit on MAC B plans.

Plan codes: PT70787 R063738 MTI1700 STI1700 C000100
Facets codes: MED-FS008831 (base) DRU-BR003188 (base)
Billing arrangement: ee, ee+spouse, ee+children, fam

BlueCross BlueShield of North Carolina

North Carolina Retail Merchants Association

Effective January 1, 2025

Blue Options 1-2-3

Prepared By

WILLIAM H HARTSFIELD JR

Prospect # 418336
Quote # 6442597

The benefit highlight is a summary of Blue Options 1-2-3 benefits. This is meant only to be a summary. You will also be receiving a Summary of Benefits and Coverage document (referred to as an SBC) required under Health Care Reform. Both documents are provided as a convenience to compare available health plan coverage options. Final interpretation of the Blue Options 1-2-3 health plan 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 the Blue Options 1-2-3 benefit booklet from Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Customer Service.

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

The amounts that appear on this benefit highlight 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, if applicable.*	**In-network**	**Out-of-network** [1]
Embedded Deductibles		
Individual (per Benefit Period)	$3,500	$7,000
Family (per Benefit Period)	$7,000	$14,000
Embedded Out-of-Pocket Limits		
Individual (per Benefit Period)	$7,000	$14,000
Family (per Benefit Period)	$14,000	$28,000
Benefit Maximums:		
Lifetime Total Dollar Maximum	Unlimited	Unlimited
Lifetime Infertility Benefit Maximum		
Ovulation Induction Cycles *(with or without insemination, per Member, in all places of service)*	3 Cycle Limits	
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. There are no limits on therapy and nutritional counseling visits related to mental illness diagnoses.*		
Physical, Occupational and Chiropractic Therapies (combined)	30 visits	
Speech Therapy	30 visits	
Adaptive Behavior Treatment	Unlimited	
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 visits	
Nutritional Counseling	30 visits	

Level 1	**In-network**	**Out-of-network** [1]
Preventive Care (See hospital based clinics-Level 3) (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
Primary Care Office-based Services *Includes all Office Visits regardless of diagnosis (including medical, therapies and pre-natal/post-delivery care unable to be included in the global delivery fee). Includes Office Surgery, Consultation, and X-rays. For these services provided by a specialist, including a Behavioral Health provider, see Level 3 Benefits.*		
Primary Care Provider	$35	60% after deductible
Log in to Blue Connect to select your Primary Care Provider (PCP). Your copay is waived for your first 3 visits to your selected PCP.		
Vendor Telehealth Vendor Telehealth Includes Telehealth services for Primary Care, Acute Care, Mental Health Teletherapy, Dermatology, and Nutritional Counseling.	No Charge	Benefits not available

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

Level 2	In-network	Out-of-network [1]
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.)If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. You may reduce your coinsurance by 10% simply by utilizing an inpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Inpatient Admission Copay	$250 per admission, then	$500 per admission, then
Hospital and Hospital Based Services	30% after deductible	60% after deductible
Inpatient Professional Services		
Professional Services	30% after deductible	60% after deductible
Skilled Nursing Facility	30% after deductible	60% after deductible
Inpatient Home Health Care and Hospice Care	30% after deductible	60% after deductible
Emergency Room Visit* (with Inpatient Admission)	30% after deductible	
*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.		

Level 3	In-network	Out-of-network [1]
Specialist Office-Based Services		
Professional Services	50% after deductible	60% after deductible
Specialist Outpatient Facility-Based Service		
Professional Services	50% after deductible	60% after deductible
Mental Health and Substance Use Disorder Office-Based Services	50% after deductible	60% after deductible
Mental Health and Substance Use Disorder Outpatient Services	50% after deductible	60% after deductible
Ambulance Services	50% after deductible	50% after deductible
Urgent Care Services	$100	$200
Emergency Room Visit* (with or without Observation)	50% after deductible	
*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.		
Outpatient Hospital Services	50% after deductible	60% 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 EEGs, EKGs, pulmonary function tests, rehabilitative, habilitative and other therapies.		
If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. You may reduce your coinsurance by 10% simply by utilizing an outpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Outpatient Diagnostic Services		
Outpatient lab tests	50% after deductible	60% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including physician's office, Durable Medical Equipment, Home Infusion Therapy, Medical Supplies, Orthotic Devices and Prosthetic Appliances	50% after deductible	60% after deductible

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

Prescription Drugs	**In-network**	**Out-of-network** [1]
Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bluecrossnc.com/preventive	0% no deductible	0% no deductible

Prescription Drug copayments, coinsurance* and deductibles* (*if applicable) apply to the Out-of-Pocket limit.*
Up to a 30-day supply is one copayment. A 31-60-day supply is two copayments. A 61-90-day supply is three copayments.

Essential 5 Tier Commercial Formulary, Broad Network. MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed).
Prior Plan approval, step therapy and quantity limits may apply.

Tier 1 Drugs	$15	$15
Tier 2 Drugs	$45	$45
Tier 3 Drugs	$85	$85
Tier 4 Drugs	$105	$105
Tier 5 Drugs	25%	25%

Diabetic Supplies obtained at the pharmacy will apply to a drug tier. Check your benefit booklet for additional details.
There is a $50 per Prescription Minimum and a $200 per Prescription Maximum for each 30-day supply of Tier 5 drugs.
Any Out-of-Network charges over the allowed amount are not included in this maximum.

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.

[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 1-2-3

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
Your benefits provide access to a variety of wellness programs and services to help you stay healthy. These include nurse support for chronic conditions, pregnancy and behavioral health, as well as tobacco cessation programs and exclusive member discounts on things like gym memberships, glasses, hearing aids and more. You can also access a wide selection of online and digital health and wellness tools and resources at bluecrossnc.com to help you 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, or as specifically covered by your health benefit plan
- For reversal of sterilization
- 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.

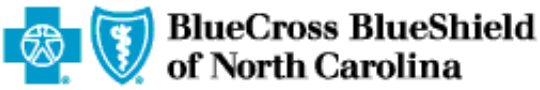
MAC B
When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND-NAME PRESCRIPTION DRUG, your cost may be higher.

Please note: You may pay a different amount in certain situations when choosing between GENERIC and BRAND-NAME PRESCRIPTION DRUGS. If you decide you want the BRAND-NAME drug on the higher tier instead of the GENERIC equivalent on the lower tier, you will pay the BRAND-NAME copayment or coinsurance plus the cost difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT. For PRESCRIPTION DRUGS received from an OUT-OF-NETWORK pharmacy, you will also pay any charges over the ALLOWED AMOUNT.

You may not be required to pay the difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT for certain BRAND-NAME PRESCRIPTION DRUGS, if these criteria are met: 1) the BRAND-NAME PRESCRIPTION DRUG is on the Narrow Therapeutic Index (NTI). See [ncbop.org/faqs/Pharmacist/faq_NTIDrugs.htm] for a current list of these drugs; or 2) your PROVIDERS has required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts may still apply.

From time to time, MEMBERS may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce PRESCRIPTION DRUG costs. NOTE: Penalty does not count towards out of pocket limit on MAC B plans.

Plan codes: PT70824 R063738 MTI1900 STI1900 C000100
Facets codes: MED-FS008919 (base) DRU-BR003188 (base)
Billing arrangement: ee, ee+spouse, ee+children, fam



North Carolina Retail Merchants Association

Effective January 1, 2025

Blue Options with HSA Fund

Prepared By

WILLIAM H HARTSFIELD JR

Prospect # 418336
Quote # 6442598

The benefit highlight is a summary of Blue Options benefits. This is meant only to be a summary. You will also be receiving a Summary of Benefits and Coverage document (referred to as an SBC) required under Health Care Reform. Both documents are provided as a convenience to compare available health plan coverage options. Final interpretation of the Blue Options health plan 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 the Blue Options benefit booklet from Blue Cross and Blue Shield of North Carolina (Blue Cross NC) Customer Service.

The plan is intended to be a high deductible health plan (HDHP) that qualifies its members to contribute to a health savings account (HSA), unless its members are otherwise ineligible under applicable federal requirements. Please consult a qualified tax advisor if you are unsure about whether or not you are ineligible. In addition, the DEDUCTIBLE and OUT-OF-POCKET LIMIT amounts listed in the Summary of Benefits may be revised each year in accordance with Internal Revenue Service (IRS) rulings.

Blue Options with HSA Fund Benefit Highlights (PPO)

The amounts that appear on this benefit highlight 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, if applicable.*	**In-network**	**Out-of-network** [1]
Embedded Deductibles		
Individual (per Benefit Period)	$5,000	$10,000
Family Total (per Benefit Period)	$10,000	$20,000
Embedded Out-of-Pocket Limits		
Individual (per Benefit Period)	$8,300	$16,600
Family Total (per Benefit Period)	$16,600	$33,200
Benefit Maximums:		
Lifetime Total Dollar Maximum	Unlimited	Unlimited
Lifetime Infertility Benefit Maximum		
Ovulation Induction Cycles *(with or without insemination, per Member, in all places of service)*	3 Cycle Limits	

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. There are no limits on therapy and nutritional counseling visits related to mental illness diagnoses.

Physical, Occupational and Chiropractic Therapies (combined)	30 visits
Speech Therapy	30 visits
Adaptive Behavior Treatment	Unlimited
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 visits
Nutritional Counseling	30 visits

Physician Office Services

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

Office Visits *Includes all Office Visits regardless of specialty or diagnosis (including medical, infertility, therapies and pre-natal/post-delivery care unable to be included in the global delivery fee). Includes Office Surgery, Consultation, Labs, and X-rays, unless otherwise specified.*		
Primary Care Provider	30% after deductible	60% after deductible
Specialist	30% after deductible	60% after deductible
Mental Health and Substance Use Disorder Office-Based Services	30% after deductible	60% after deductible
Vendor Telehealth *Includes Telehealth services for primary care, acute care, mental health teletherapy, dermatology, and nutritional counseling.*	0% after deductible	Benefits not available
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

Blue Options with HSA Fund Benefit Highlights (PPO)

Urgent and Emergency Care	In-network	Out-of-network [1]
Ambulance Services	30% after deductible	30% after deductible
Emergency Room Visit* (with or without Observation)	30% after deductible	30% after deductible
Emergency Room Visit* (with Inpatient Admission)	30% after deductible	30% after deductible
Urgent Care Services	30% after deductible	60% after deductible

**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.) If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. Depending on your plan, you may reduce your coinsurance by 10% simply by utilizing an inpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Inpatient Hospital Facility Services	30% after deductible	60% after deductible
Inpatient Hospital Professional Services	30% after deductible	60% after deductible

Outpatient Services		
If you receive care at a Blue Distinction Center (BDC), your out-of-pocket expenses may be less. Depending on your plan, you may reduce your coinsurance by 10% simply by utilizing an outpatient Blue Distinction Center. Please visit [https://www.bluecrossnc.com/bdc] for more information, including the most up-to-date list of specialties, and to find a Blue Distinction® Center near you.		
Hospital Based or Free-standing Facility Services *(other than preventive services above)*	30% after deductible	60% after deductible
Outpatient lab tests	30% after deductible	60% 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	30% after deductible	60% after deductible
Mental Health and Substance Use Disorder Outpatient Services	30% after deductible	60% after deductible

Other Services		
Skilled Nursing Facility	30% after deductible	60% after deductible
Home Health Care and Hospice	30% after deductible	60% after deductible
Durable Medical Equipment, Medical Supplies, Orthotic Devices and Prosthetic Appliances	30% after deductible	60% after deductible
CT scans, MRIs, MRAs and PET scans in any location, including a physician's office	30% after deductible	60% after deductible

Blue Options with HSA Fund Benefit Highlights (PPO)

Prescription Drugs	**In-network**	**Out-of-network** [1]
Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bluecrossnc.com/preventive	0% no deductible	0% no deductible

All pharmacy coinsurance amounts below apply after the medical deductible is satisfied, and apply to the medical Out-of-Pocket limit.

Essential 5 Tier Commercial Formulary, Broad Network. MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed).
Prior Plan approval, step therapy and quantity limits may apply.

Prescription drugs	30% after deductible
Enhanced Preventive Drugs	30% no deductible

Any drugs from the Enhanced Preventive Drug List prescribed for a preventive purpose is covered at 30% no deductible.

Diabetic Supplies obtained at the pharmacy will apply to a drug tier. Check your benefit booklet for additional details

You are responsible for charges over the allowed amount received from an Out-of-Network pharmacy, and those amounts are not included in the Deductible or Out-of-Pocket limit.

Limits apply to Infertility drugs, refer to your benefit booklet.

[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 with HSA Fund

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
Your benefits provide access to a variety of wellness programs and services to help you stay healthy. These include nurse support for chronic conditions, pregnancy and behavioral health, as well as tobacco cessation programs and exclusive member discounts on things like gym memberships, glasses, hearing aids and more. You can also access a wide selection of online and digital health and wellness tools and resources at bluecrossnc.com to help you take charge of your health!

Health Savings Account
This plan, with an HSA Fund, is not a Health Savings Account (HSA), but it instead is a health insurance plan intended to be paired with an HSA. The HSA is provided to you directly by a separate HSA Administrator. An HSA is a savings vehicle for medical care expenses. It helps to pay the expenses that insurance does not pay. Individuals and employers can contribute money into an HSA on a tax-deductible or pre-tax basis for individuals. If used to pay for qualified health care expenses, your HSA account's growth and use is tax-free. In addition, HSAs roll over from year to year and are fully portable if an individual changes jobs. HSAs can only be opened by and contributed to on behalf of individuals who are covered under a qualified High Deductible Health Plan (HDHP). For more information on your HSA eligibility if you have other, additional health coverage, consult your tax advisor.

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 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.

MAC B
When choosing a PRESCRIPTION DRUG, you and your DOCTOR should discuss whether a lower-cost PRESCRIPTION DRUG could provide the same results as a more expensive PRESCRIPTION DRUG. If you choose a BRAND-NAME PRESCRIPTION DRUG, your cost may be higher.

Please note: You may pay a different amount in certain situations when choosing between GENERIC and BRAND-NAME PRESCRIPTION DRUGS. If you decide you want the BRAND-NAME drug on the higher tier instead of the GENERIC equivalent on the lower tier, you will pay the BRAND-NAME copayment or coinsurance plus the cost difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT. For PRESCRIPTION DRUGS received from an OUT-OF-NETWORK pharmacy, you will also pay any charges over the ALLOWED AMOUNT.

You may not be required to pay the difference between the BRAND-NAME ALLOWED AMOUNT and the GENERIC ALLOWED AMOUNT for certain BRAND-NAME PRESCRIPTION DRUGS, if these criteria are met: 1) the BRAND-NAME PRESCRIPTION DRUG is on the Narrow Therapeutic Index (NTI). See [ncbop.org/faqs/Pharmacist/faq_NTIDrugs.htm] for a current list of these drugs; or 2) your PROVIDERS has required the use of a BRAND-NAME PRESCRIPTION DRUG to treat your condition. Applicable copayment or coinsurance amounts may still apply.

From time to time, MEMBERS may receive a reduced or waived copayment and/or coinsurance on designated drugs in connection with a program designed to reduce PRESCRIPTION DRUG costs. NOTE: Penalty does not count towards out of pocket limit on MAC B plans.

Plan codes: PB93104 R063376 MP80700 SP80700 C000100
Facets codes: MED-FS009033 (base) DRU-BR002590 (base)
Billing arrangement: ee, ee+spouse, ee+children, fam