BlueCross BlueShield of North Carolina

North Carolina Forestry Association

Effective January 1, 2025

Blue Options

Prepared By

WILLIAM H HARTSFIELD JR

Prospect # 405620
Quote # 6356702

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)	$1,000	$2,000
Family Total (per Benefit Period)	$2,000	$4,000
Embedded Out-of-Pocket Limits		
Individual (per Benefit Period)	$3,000	$6,000
Family Total (per Benefit Period)	$6,000	$12,000
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	$15	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	$30	50% after deductible
Mental Health and Substance Use Disorder Office-Based Services	$10	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	$30	$60

**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	$4	$4
Tier 2 Drugs	$15	$15
Tier 3 Drugs	$30	$30
Tier 4 Drugs	$45	$45
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 $100 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: PB93287 R063331 MP99960 SP99960 C002900
Facets codes: MED-FS009482 (base) DRU-BR002545 (base)
Billing arrangement: ee, ee+spouse, ee+children, fam

BlueCross BlueShield of North Carolina

North Carolina Forestry Association

Effective January 1, 2025

Blue Options 1-2-3

Prepared By

WILLIAM H HARTSFIELD JR

Prospect # 405620
Quote # 6410100

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	$25	$25
Tier 3 Drugs	$45	$45
Tier 4 Drugs	$85	$85
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 R063357 MTI1900 STI1900 C000100
Facets codes: MED-FS008925 (base) DRU-BR002571 (base)
Billing arrangement: ee, ee+spouse, ee+children, fam

BlueCross BlueShield of North Carolina

Uniform Benefit Changes (UBC)

for Large Group Plans (including Balanced Funding)

In a continuing effort to offer quality, cost-effective health care coverage, the following changes have been made to Blue Cross and Blue Shield of North Carolina (Blue Cross NC) standard benefits. These changes apply to Fully Insured (FI) and Self-Funded (ASO) including Balanced Funding group plans. These changes are effective at the group's effective/renewal date.

Please note, your plan documents govern all benefit determinations and in the case of conflict with this document your plan controls. Always refer to the plan documents for specific benefit coverage and limitations.

New Benefit Design	Products/Plans Impacted	For Non-Grandfathered Groups with Effective Dates on or after 01/1/2025
	Blue Options® All Copay BlueHPN® All Copay	All Copay plan design is included in the Blue Options® and BlueHPN® product families for the FI and ASO segments. All Copay medical plans can only be paired with All Copay Rx plans.
Existing Benefit Design	**Products/Plans Impacted**	**For Non-Grandfathered Groups with Effective Dates on or after 01/1/2025**
Musculoskeletal (MSK) bundle benefit for shoulder, knee and hip replacements is covered at deductible and coinsurance. **Bundle includes pre- and post-op visits, surgery procedure, and rehabilitation therapy.**	Blue Options® Blue Options® 1-2-3 SM BlueHPN® BlueHPN® (1-2-3 Plan Design) Blue Options® All Copay BlueHPN® All Copay	MSK bundle benefit for shoulder, knee, and hip replacements applies a $750 copay for copay plans. Note: Deductible and coinsurance plans will remain the same.
Emergency room (ER) benefit when admitted applies either copay or deductible and coinsurance.	Blue Options® Blue Options® 1-2-3 SM BlueHPN® BlueHPN® (1-2-3 Plan Design) Blue Options® All Copay BlueHPN® All Copay	ER benefit when admitted applies deductible and coinsurance.
For most plans, infertility coverage is limited to subscriber/spouse/domestic partner.	Blue Options® Blue Options® 1-2-3 SM BlueHPN® BlueHPN® (1-2-3 Plan Design) Blue Options® All Copay BlueHPN® All Copay	Add infertility benefit coverage for eligible dependents.

BlueCross BlueShield of North Carolina

Existing Benefit Design	Products/Plans Impacted	For Non-Grandfathered Groups with Effective Dates on or after 01/1/2025
Credit cards may be issued to cover travel expenses for approved transplant services.	Blue Options® Blue Options® 1-2-3SM BlueHPN® BlueHPN® (1-2-3 Plan Design) Blue Options® All Copay BlueHPN® All Copay	Credit cards will be discontinued, and members may submit a claim for reimbursement after travel expenses are incurred. Existing credit cards can be used until 2025 group renewal effective date. Travel benefit for transplant services will be covered within the benefit plan of the member. • HSA-eligible plans = 0% after deductible • All Copay = Level A ($0 copay) • All other plans = No Charge
Travel expenses and reimbursement process associated with pregnancy-related, gender affirming, and mental health and substance use disorder services for non-HSA eligible plans are covered at deductible and coinsurance.	Blue Options® Blue Options® 1-2-3SM BlueHPN® BlueHPN® (1-2-3 Plan Design) Blue Options® All Copay BlueHPN® All Copay	Travel expenses associated with pregnancy-related, gender affirming, and mental health and substance use disorder services for non-HSA eligible deductible and coinsurance plans are covered at no charge.
Vendor telehealth standard benefit covers: • **Acute Care + Behavioral Health**	Blue Options® Blue Options® 1-2-3SM BlueHPN® BlueHPN® (1-2-3 Plan Design) Blue Options® All Copay BlueHPN® All Copay	All groups, except ASO 250+, receive the standard vendor telehealth benefit as indicated below, with no option to exclude. <u>Standard</u> Blue Options® <u>(PPO) offering:</u> • *Primary360* includes Primary Care + Acute Care + Mental Health Care Teletherapy + Dermatology + Nutritional Counseling <u>Standard</u> BlueHPN® <u>(EPO) offering:</u> • Telehealth includes Acute Care + Mental Health Care Teletherapy <u>All vendor telehealth services are provided to members at the following cost-shares:</u> • HSA-eligible plans = 0% after deductible • All other plans = No Charge/$0 Note: Groups ASO 250+ will have the option to exclude.
Group plans with a grandfathered status do not apply a benefit differential for using Blue Distinction Center (BDC).	Blue Options®	Group plans with a grandfathered status apply a 10% benefit differential when using a BDC.

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Existing Benefit Design	Products/Plans Impacted	For Non-Grandfathered Groups with Effective Dates on or after 01/1/2025
Diabetic supplies are listed by tier on the applicable formulary. The benefit overrides the tier and applies 25% coinsurance.	Blue Options® Blue Options® 1-2-3SM BlueHPN® BlueHPN® (1-2-3 Plan Design) Blue Options® All Copay BlueHPN® All Copay	Diabetic supplies are covered at the assigned drug tier cost share for the formulary.
Standard ASO plans have coverage for weight loss management medications.	Blue Options® Blue Options® 1-2-3SM BlueHPN® BlueHPN® (1-2-3 Plan Design) Blue Options® All Copay BlueHPN® All Copay	Standard ASO plans do not cover weight loss management medications.
Mental Health Substance Use (MHSU) office visit is currently covered with a member cost share of $10.	Blue Options® Blue Options® 1-2-3SM BlueHPN® BlueHPN® (1-2-3 Plan Design)	1-2-3 plans will now cover the MHSU office visits at deductible and Level 3 coinsurance. Simple and Hybrid plan designs will cover MHSU office visits at deductible and coinsurance.
Out of Pocket (OOP) Limits **HSA OOP Limit:** $8,050 Individual / $16,100 Family **Non-HSA OOP Limit:** $9,450 Individual / $18,900 Family	Blue Options® Blue Options® 1-2-3SM BlueHPN® BlueHPN® (1-2-3 Plan Design) Blue Options® All Copay BlueHPN® All Copay	OOP Limits: HSA OOP Limit: $8,300 Individual / $16,600 Family Non-HSA OOP Limit: $9,200 Individual / $18,400 Family