2024 SUMMARY OF COVERAGE - MEDICAL ADVANTAGE AND STANDARD PLANS

Program Features	Advantage Plan (In-Network) *	Advantage Plan (Out-of-Network)	Standard Plan (In-Network) *	Standard Plan (Out-of-Network)
Health Savings Account Eligible Plan?	Yes		No	
Annual Deductible	$1,600 if individual coverage; $3,200 if family coverage	$3,200 if individual coverage; $6,400 if family coverage	$800 per individual; $2,400 per family	$1,600 per individual; $4,800 per family
Annual Out-of-Pocket Maximum Includes deductible and co-insurance	$5,600 per individual; $11,200 per family	$11,200 per individual; $22,400 per family	$4,200 per individual; $12,600 per family	$8,500 per individual; $25,500 per family
Physician Services				
Program Features	**Advantage Plan (In-Network) ***	**Advantage Plan (Out-of-Network)**	**Standard Plan (In-Network) ***	**Standard Plan (Out-of-Network)**
Primary Care Physician (PCP) Office Visit**	Plan pays 90% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Teladoc® Telephonic and video office visit or behavioral health consult	Plan pays 90% after deductible	N/A	Plan pays 90% with no deductible	N/A
Specialist Office Visit**	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Preventive Physicals including Immunizations Birth to 1 year: seven exams Age 1-3: three exams per year Over age 3: one exam every 12 months	Plan pays 100% with no deductible	Plan pays 60% after deductible	Plan pays 100% with no deductible	Plan pays 60% after deductible
Preventive OB/GYN One exam per calendar year PAP exam age 21 and over	Plan pays 100% with no deductible	Plan pays 60% after deductible	Plan pays 100% with no deductible	Plan pays 60% after deductible
Preventive Mammography	Plan pays 100% with no deductible	Plan pays 60% after deductible	Plan pays 100% with no deductible	Plan pays 60% after deductible

Physician Services				
Program Features	**Advantage Plan (In-Network) ***	**Advantage Plan (Out-of-Network)**	**Standard Plan (In-Network) ***	**Standard Plan (Out-of-Network)**
Routine Eye Exam One exam every 12 months	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Routine Hearing Exam One exam every 12 months	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient Surgery Outside physician's office	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Inpatient Surgery	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Anesthesia	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Physician Hospital Visits	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Allergy Testing & Treatment – Specialist PCP is paid at PCP level	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Acupuncture Limit: 20 visits per calendar year	Plan pays 80% after deductible	Plan pays 80% after in-network deductible	Plan pays 80% after deductible	Plan pays 80% after in-network deductible
Chiropractic Services Limit: 20 visits per calendar year	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible

Hospital and Other Services				
Program Features	**Advantage Plan (In-Network) ***	**Advantage Plan (Out-of-Network)**	**Standard Plan (In-Network) ***	**Standard Plan (Out-of-Network)**
Inpatient Facility	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible (deductible waived for newborns)	Plan pays 60% after deductible
Outpatient Surgery Facility	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Ambulance	Plan pays 80% after deductible	Plan pays 80% after in-network deductible	Plan pays 80% after deductible	Plan pays 80% after in-network deductible

Hospital and Other Services				
Program Features	**Advantage Plan (In-Network) ***	**Advantage Plan (Out-of-Network)**	**Standard Plan (In-Network) ***	**Standard Plan (Out-of-Network)**
Emergency Room	Plan pays 80% after deductible	Plan pays 80% after in-network deductible	Plan pays 80% after deductible	Plan pays 80% after in-network deductible
Urgent Care Facility	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Walk-In Clinic Convenience Care Clinics	Plan pays 90% after deductible	Plan pays 60% after deductible	Plan pays 90% after deductible	Plan pays 60% after deductible
Diagnostic X-ray & Laboratory Outpatient and independent lab; not in doctor's office	Plan pays 80% after deductible; 100% no deductible if associated with preventive testing during a preventive exam	Plan pays 60% after deductible	Plan pays 80% after deductible; 100% no deductible if associated with preventive testing during a preventive exam	Plan pays 60% after deductible
Complex Imaging MRI, CT scan	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Infertility Services	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Bariatric Surgery	Plan pays 80% after deductible for services provided by a Blue Distinction Center; 60% after deductible for services provided by other BCBS network providers	Not covered	Plan pays 80% after deductible for services provided by a Blue Distinction Center; 60% after deductible for services provided by other BCBS network providers	Not covered
Transplants	Plan pays 80% after deductible for services provided by a Blue Distinction Center; 60% after deductible for services provided by other BCBS network providers	Plan pays 60% after deductible	Plan pays 80% after deductible for services provided by a Blue Distinction Center; 60% after deductible for services provided by other BCBS network providers	Plan pays 60% after deductible

Hospital and Other Services				
Program Features	**Advantage Plan (In-Network) ***	**Advantage Plan (Out-of-Network)**	**Standard Plan (In-Network) ***	**Standard Plan (Out-of-Network)**
Spine Surgery	Plan pays 80% after deductible for services provided by a Blue Distinction Center; 60% after deductible for services provided by other BCBS network providers	Plan pays 60% after deductible	Plan pays 80% after deductible for services provided by a Blue Distinction Center; 60% after deductible for services provided by other BCBS network providers	Plan pays 60% after deductible
Skilled Nursing Facility Limited to 100 days per calendar year	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Home Health Care	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Private Duty Nursing	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Hospice Care	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Short-Term Rehabilitation Includes physical, occupational & speech therapy. Limited to combined 60 visits per calendar year for physical and occupational therapy; 60 visits per calendar year for speech therapy.	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Applied Behavior Analysis (ABA) therapy	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Durable Medical Equipment Foot orthotics limited to $300 per calendar year	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible

Women's Preventive Services				
Program Features	**Advantage Plan (In-Network) ***	**Advantage Plan (Out-of-Network)**	**Standard Plan (In-Network) ***	**Standard Plan (Out-of-Network)**
Well Woman Visits Prenatal Visits during pregnancy Preventive	Plan pays 100% with no deductible	Plan pays 60% after deductible	Plan pays 100% with no deductible	Plan pays 60% after deductible
Gestational Diabetes Screening Five specific diabetes lab tests during pregnancy	Plan pays 100% with no deductible	Plan pays 60% after deductible	Plan pays 100% with no deductible	Plan pays 60% after deductible
Breast Feeding Support, Supplies and Counseling Comprehensive lactation support and six counseling visits per year	Plan pays 100% with no deductible	Plan pays 60% after deductible	Plan pays 100% with no deductible	Plan pays 60% after deductible
Health Screenings and Counseling As part of Preventive annual exam or well woman exam	Plan pays 100% with no deductible	Plan pays 60% after deductible	Plan pays 100% with no deductible	Plan pays 60% after deductible
Contraceptive Methods and Counseling Office visits for administration of contraceptive devices; two visits per year for contraceptive counseling; female sterilization	Plan pays 100% with no deductible	Plan pays 60% after deductible	Plan pays 100% with no deductible	Plan pays 60% after deductible

RAI Health Centers		
Program Features	**Advantage Plan**	**Standard Plan**
Office Visit	$30 until deductible is met, Plan pays 100% after deductible	Plan pays 100%
Office Procedure	$10-$15 until deductible is met, Plan pays 100% after deductible	Plan pays 100%
Lab Work or Rapid Tests	$3 per test until deductible is met, Plan pays 100% after deductible	Plan pays 100%
Generic Prescriptions	$4 until deductible is met, Plan pays 100% after deductible	Plan pays 100%

*Members who do not live in a Blue Cross Blue Shield network area will be offered Out-of-Area coverage at the Standard Plan (In-Network) level.

**PCP refers to an in-network provider who has been designated by BCBSNC as a PCP. Specialist is a doctor who is recognized by BCBSNC as specialized in the area of medical practice.

In-Network and Out-of-Network deductibles and out-of-pocket maximums are accumulated separately; they are not combined.

Prescription Drug Program – Express Scripts (ESI)		
	Advantage Plan	**Standard Plan**
	(deductible applies unless on the ESI preventive drug list)	**(deductible does not apply)**
Preferred ESI Participating Retail Pharmacy Up to a 90-day supply		
Generic or Preferred Brand	Plan pays 80% after deductible	Plan pays 80%
Non-Preferred Brand	Plan pays 65% after deductible	Plan pays 65%
Non-Preferred ESI Participating Retail Pharmacy Up to a 90-day supply		
Generic or Preferred Brand	Plan pays 75% after deductible	Plan pays 75%
Non-Preferred Brand	Plan pays 60% after deductible	Plan pays 60%
Specialty Drugs*		
Generic or Preferred Brand	Plan pays 80% after deductible	Plan pays 80%
Non-Preferred Brand	Plan pays 65% after deductible	Plan pays 65%
ESI Mail Service Up to a 90-day supply		
Generic or Preferred Brand	Plan pays 85% after deductible	Plan pays 85%
Non-Preferred Brand	Plan pays 65% after deductible	Plan pays 65%
Affordable Care Act Preventive Care Services	Plan pays 100% as required under Health Care Reform • Drugs (including over-the-counter drugs) which are prescribed by your doctor and required to be covered as preventive care under the Affordable Care Act • Brands will be covered when no generic equivalent or alternative in any given drug class • Brands will be covered when a generic is available, and the prescriber indicates that the generic is not medically appropriate	
Women's Preventive Services FDA approved	Plan pays 100% as required under Health Care Reform • All generic contraceptive methods and devices • Brands will be covered when no generic equivalent or alternative in any given drug class • Brands will be covered when a generic is available, and the prescriber indicates that the generic is not medically appropriate • Over-the-Counter (OTC) items are not covered except for emergency contraceptives and devices prescribed by a physician and filled from a pharmacy	

* Specialty drugs must be purchased through the ESI Accredo Specialty Pharmacy.

Coverage is only offered on drugs purchased from an ESI Participating Pharmacy or ESI Home Delivery.

Only drugs on the ESI Formulary are covered. Go to express-scripts.com for the most recent formulary.

All benefits are subject to the terms and provisions of the various employee benefit programs.

2024 SUMMARY OF COVERAGE
DENTAL PLAN

Feature/Type of Care	Plan Benefits
Annual Deductible – Waived for diagnostic and preventive services	$50 per individual; $150 per family
Calendar-Year Maximum Benefits – Applies to all services except Orthodontia	$2,000 per individual
Diagnostic and Preventive Services* – Includes: • Preventive oral examinations • Cleaning, scaling and polishing of teeth (Preventive prophylaxis) • Topical applications of fluoride for dependent children • Full-mouth radiographs • Supplementary bitewing radiographs • Topical application of plastic sealants on dependent children • Installation and adjustment of fixed or removable space maintainers for dependent children and adults – only to replace prematurely-lost teeth	Plan pays 100% of billed charge with no deductible
Emergency Treatment – When necessary to ease pain or infection, but not treatment to cure the pain or discomfort, such as extractions or permanent fillings.	Plan pays 100% of billed charge with no deductible
Basic Restorative Services* – Includes: • Repairing and restoring teeth, including amalgam, silicate and composite fillings • Oral surgery of the mouth including tooth extractions and pre-prosthetic surgery • General anesthesia • Treatment of teeth having damaged pulp, including root canal therapy (endodontics) • Treatment of gums and supporting structures (periodontics) • Cleaning and scraping of pockets in the gum tissue (periodontal prophylaxis)	Plan pays 80% of billed charge after the annual deductible
Major Restorative Services* – Includes: • Crowns, inlays and onlays • Installation and addition of full or partial dentures or fixed bridgework • Dental implants • Replacement or alteration of full or partial dentures or fixed bridgework • Occlusal guards (for tooth grinding only)	Plan pays 50% of billed charge after the annual deductible
Orthodontia Services – Coverage is limited to dependent children	Plan pays 50% of billed charge after the annual deductible ($2,500 lifetime maximum per child)
Non-Surgical Treatment of Temporomandibular Joint (TMJ) Disorders	Plan pays 80% of billed charge after the annual deductible ($1,000 lifetime maximum per person)

* See the SPD for details of limitations. Request a Pre-treatment Estimate for services over $250, and on all orthodontic, periodontal or fixed bridgework regardless of expected cost.

2024 SUMMARY OF COVERAGE
VISION PLAN

Co-Payments	
Eye exam (one per calendar year)	$10.00
Eyeglass frames and/or lenses (lenses - once per calendar year; frames - every other calendar year)	$15.00
Contact Lens Fitting In-Network Providers	
Standard (one per calendar year)	Covered in Full
Specialty (one per calendar year)	Up to $50
In-Network Benefits (after co-payment and once per calendar year unless otherwise noted)	
Ophthalmologist and optometrist exams; single vision, bifocal, trifocal, lenticular lenses, standard progressive lenses, factory scratch coatings and polycarbonate lenses for children; medically-necessary contact lenses	Covered in full
Elective contact lenses (in lieu of eyeglass lenses and frames benefit) (copay not applicable)	Up to $150
Frames (standard) (every other calendar year)	Up to $150
Out-of-Network Benefits (after co-payment and once per calendar year unless otherwise noted)	
Ophthalmologist exam	Up to $44
Optometrist exam	Up to $39
Single vision lenses	Up to $34
Bifocal lenses	Up to $48
Trifocal lenses	Up to $64
Lenticular lenses	Up to $88
Medically-necessary contact lenses (copay not applicable)	Up to $210
Elective contact lenses (in lieu of eyeglass lenses and frames benefit) (copay not applicable)	Up to $100
Frames (standard) (every other calendar year)	Up to $77

The Standard contact lens fitting applies to an existing lens user who wears disposable, daily wear, or extended wear lens only.

The Specialty contact lens fitting applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses.