10-01-2019 to 9-30-2020
NORTH CAROLINA BAR ASSOCIATION HEALTH BENEFIT TRUST
***PROPOSED* COMPARISON OF BENEFITS**
This illustration is for Benefits Highlights only
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COVERED BENEFITS	**BLUE OPTIONS PLAN 1**		**BLUE OPTIONS PLAN 2**		**BLUE OPTIONS PLAN 3**		**BLUE OPTIONS PLAN 4**		**BLUE OPTIONS PLAN 5**	
	In-Network	Out-of Network	In-Network	Out-of Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible per Plan Year										
Individual	$750	$1,500	$1,000	$2,000	$1,500	$3,000	$2,000	$4,000	$3,500	$7,000
Family	$1,500	$3,000	$2,000	$4,000	$3,000	$6,000	$4,000	$8,000	$7,000	$14,000
Out of Pocket Limit										
Individual	$1,500	$3,000	$3,000	$6,000	$5,000	$10,000	$6,000	$12,000	$ 7,000	$14,000
Family	$3,000	$6,000	$6,000	$12,000	$10,000	$20,000	$12,000	$24,000	$14,000	$28,000
NOTE: Out of Pocket limit **includes** the deductible, co-pays and co-insurance for both Medical and Pharmacy benefits.										
Physician Office Services										
Primary Care Provider TeleHealth Consult	$30 copay	20%	$30 copay	30%	$35 copay	40%	$40 copay	50%	$45 copay	50%
Specialist	$50 copay	20%	$50 copay	30%	$60 copay	40%	$65 copay	50%	$75 copay	50%
Preventive Care: Primary Care Provider or Specialist	0%	No Coverage	0%	No Coverage	0%	No Coverage	0%	No Coverage	0%	No Coverage
PREVENTIVE CARE: *Well-Child Care, Well Baby Care, Immunizations, Well Woman Care- Gynecological Exams, Ovarian & Cervical Cancer Screening, Newborn Hearing Screening, Colorectal Screening, Bone Mass Measurement, Screening Mammograms, Nutritional Counseling, BRCA Screening, Cholesterol Screening , Depression Screening, Diabetes Screening, Gonorrhea Screeing, Hepatitis B & C Screening, HIV Screening, Iron Deficiency Screening, Obesity Screening & Counseling, Syphillis Screening & Routine Eye Exams (**For complete listing consult your member guide)***										
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Prescription Drugs One copayment for 30 day supply	**Tier 1** $10 copay **Tier 2** $10 copay **Tier 3** $35 copay **Tier 4** $55 copay **Tier 5** 25% **$150** maximum		**Tier 1** $10 copay **Tier 2** $10 copay **Tier 3** $35 copay **Tier 4** $55 copay **Tier 5** 25% **$150** maximum		**Tier 1** $10 copay **Tier 2** $10 copay **Tier 3** $35 copay **Tier 4** $55 copay **Tier 5** 25% **$150** maximum		**Tier 1** $10 copay **Tier 2** $10 copay **Tier 3** $40 copay **Tier 4** $65 copay **Tier 5** 25% **$150** maximum		**Tier 1** $10 copay **Tier 2** $10 copay **Tier 3** $40 copay **Tier 4** $65 copay **Tier 5** 25% **$150** maximum	
PREVENTIVE PHARMACY MEDICATIONS: *A prescription is required in order to receive the following medications at no cost: Aspirin for Cardiovascular Disease, Vitamin D, Folic Acid, Iron Supplement, OTC Contraception, Physician Assisted Contraception, Fluoride, Smoking Cessation, Bowel Preparation Agents, Pre-Natal Vitamins, & Pediatric Vitamins containing Fluoride.*										
Urgent Care Center	$50 copay		$50 copay		$60 copay		$65 copay		$75 copay	
Emergency Room	$250 copay		$250 copay		$250 copay		$250 copay		$250 copay	
Ambulance Services	0% after deductible		10% after deductible		20% after deductible		30% after deductible		40% after deductible	
Hospital & Outpatient Services										
Hospital & Outpatient Clinical services	0%	20%	10%	30%	20%	40%	30%	50%	40%	50%
Professional Services	0%	20%	10%	30%	20%	40%	30%	50%	40%	50%
Outpatient Labs & Mammograms ***with*** surgery or other services	0% after Deductible	20%	10% after Deductible	30%	20% after Deductible	40%	30% after Deductible	50%	40% after Deductible	50%
Outpatient Labs or Mammograms **without** surgery or other services when performed alone	0% No deductible	20% after Deductible	0% No deductible	30% after Deductible	0% No deductible	30% after Deductible	0% No deductible	30% after Deductible	0% No deductible	40% after Deductible
Maternity										
Office (Copy may apply)	$50 copay	20%	$50 copay	30%	$60 copay	40%	$65 copay	50%	$75 copay	50%
Hospital Services (Delivery)	0%	20%	10%	30%	20%	40%	30%	50%	40%	50%
Professional Services (Delivery)	0% after Deductible	20%	10% after Deductible	30%	20% after Deductible	40%	30% after Deductible	50%	40% after Deductible	50%
Rehab & Habilitative Therapies (30 Visit Limit)	$50 copay	20% after Deductible	$50 copay	30% after Deductible	$60 copay	40% after Deductible	$65 copay	50% after Deductible	$75 copay	50% after Deductible
Skilled Nursing Facility (60 days per benefit period)	0% after Deductible	20%	10% after Deductible	30%	20% after Deductible	40%	30% after Deductible	50%	40% after Deductible	50%
Mental Health Services & Substance Abuse										
Office	$30 copay	20%	$30 copay	30%	$35 copay	40%	$40 copay	50%	$45 copay	50%
Inpatient/Outpatient	0% after Deductible	20%	10% after Deductible	30%	20% after Deductible	40%	30% after Deductible	50%	40% after Deductible	50%
Home Health Care, Hospice, Durable Medical Equipment	0% after Deductible	20%	10% after Deductible	30%	20% after Deductible	40%	30% after Deductible	50%	40% after Deductible	50%

The deductible **must be met** before the coinsurance percentages are applied (excluding tier 5 drugs).
Out-of-Network coinsurance is calculated using the Allowed Amount. Members may be billed by out-of-network providers for the difference between the provider's charge and the Allowed Amount.

For Complete Preventive Care and Preventive Prescription information and lists, please see the complete Member Guide for your plan.

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COVERED BENEFITS	**BLUE OPTIONS HDHP Plan 10** HSA Eligible In-Network	Out-of Network	**BLUE OPTIONS HDHP Plan 15** HSA Eligible In-Network	Out-of-Network	**BLUE OPTIONS HDHP Plan 20** HSA Eligible In-Network	Out-of-Network
Deductible per Plan Year	With all High-Deductible Plans, the Deductible must be met before any benefits are paid (Excluding Preventive Care)					
For family coverage, family deductible must be met before coinsurance is applied*	***In 2019,the out-of-pocket maximum can be no more than $7,900 for an individual participating in a family plan and $15,800 for the family annually.***					
Employee	$1,750	$3,500	$3,500	$7,000	$5,000	$7,000
Family (Employee +1 or more)	$3,500	$7,000	$7,000	$14,000	$10,000	$14,000
Total Out of Pocket Maximum **(Includes Deductible)**						
Employee	$3,250	$6,500	$3,500	$7,000	$5,000	$10,000
Family (Employee +1 or more)	$6,500	$13,000	$7,000	$14,000	$10,000	$20,000
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Preventive Care	0%	No Coverage	0%	No Coverage	0%	No Coverage
PREVENTIVE CARE: *Well-Child Care, Well Baby Care, Immunizations, Well Woman Care- Gynecological Exams, Ovarian & Cervical Cancer Screening, Newborn Hearing Screening, Colorectal Screening, Bone Mass Measurement, Screening Mammograms, Nutritional Counseling, BRCA Screening, Cholesterol Screening , Depression Screening, Diabetes Screening, Gonorrhea Screeing, Hepatitis B & C Screening, HIV Screening, Iron Deficiency Screening, Obesity Screening & Counseling, Syphillis Screening & Routine Eye Exams* ***(For complete listing consult your member guide)***						
PREVENTIVE PHARMACY MEDICATIONS: *A prescription is required in order to receive the following medications at no cost to you- specific dosage & brand may apply: Aspirin for cardiovascular disease, Vitamin D, Folic Acid, Iron Supplement, OTC Contraception, Physician Assisted Contraception as Listed, Fluoride, Smoking Cessation, Bowel Preparation Agents, Pre-Natal Vitamins, & Pediatric Vitamins containing Fluoride.*						
Physician Office Services						
Primary Care Provider, TeleHealth Consult or Specialist	20% after Deductible	40%	0% after Deductible	20%	0% after Deductible	30%
Hospital & Outpatient Services						
Hospital & Outpatient Clinical services	20%	40%	0%	20%	0%	30%
Professional Services	20%	40%	0%	20%	0%	30%
Outpatient X-rays & Labs	20% after Deductible	40%	0% after Deductible	20%	0% after Deductible	30%
Maternity	20% after Deductible	40%	0% after Deductible	20%	0% after Deductible	30%
Home Health Care, Hospice, Durable Medical Equipment	20% after Deductible	40%	0% after Deductible	20%	0% after Deductible	30%
Mental Health Services						
Office	20%	40%	0%	20%	0%	30%
Inpatient/Outpatient	20% after Deductible	40%	0% after Deductible	20%	0% after Deductible	30%
Rehab & Habilitative Therapies (30 Visit Limit)	20% after Deductible	40%	0% after Deductible	20%	0% after Deductible	30%
Skilled Nursing Facility (60 days/period)	20% after Deductible	40%	0% after Deductible	20%	0% after Deductible	30%
Substance Abuse Services						
Office & Inpatient/Outpatient	20% after Deductible	40%	0% after Deductible	20%	0% after Deductible	30%
Urgent Care Center & Emergency Room	20% after Deductible	20%	0% after deductible		0% after deductible	
Ambulance Services	20% after deductible		0% after deductible		0% after deductible	
Prescription Drugs In-Network	20% after deductible		0% after deductible		0% after deductible	
Prescription Drugs Out-of-Network	Deductible (if applicable) +Co-Insurance + Charge Over In-Network Allowed Amount		Deductible (if applicable) +Co-Insurance + Charge Over In-Network Allowed Amount		Deductible (if applicable) +Co-Insurance + Charge Over In-Network Allowed Amount	

The Total Out of Pocket Maximum includes the Deductible.

Out-of-Network benefits are calculated using the Allowed Amount. Members may be billed by out-of-network providers for the difference between the provider's charge and the Allowed Amount.