## 10-01-2016 to 9-30-2017 NORTH CAROLINA BAR ASSOCIATION HEALTH BENEFIT TRUST PROPOSED COMPARISON OF BENEFITS

				This illustration is for	RISON OF BE Benefits Highlights only r additional information ar					
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	t-of Network	In-Network O	ut-of Network	In-Network Ou	ıt-of-Network	In-Network Ou	it-of-Network	In-Network Ou	t-of-Network
Deductible per Plan Year										
Individual Family	\$750 \$1,500	\$1,500 #3,000	\$1,000	\$2,000 \$4,000	\$1,500 \$3,000	\$3,000	\$2,000	\$4,000	\$3,000 \$6,000	\$6,000 \$12,000
Out of Pocket Limit	\$1,500	\$3,000	\$2,000	\$4,000	\$3,000	\$6,000	\$4,000	\$8,000	\$6,000	\$12,000
Individual	\$1,500	\$3,000	\$3,000	\$6,000	\$5,000	\$10,000	\$6,000	\$12,000	\$6,500	\$13,000
Family	\$3,000	\$6,000	\$6,000	\$12,000	\$10,000	\$20,000	\$12,000	\$24,000	\$13,000	\$26,000
	NOTE: Out	t of Pocket limit	t <u>includes</u> the d	eductible, co-pa	s and co-insuran	ice for both Med	lical and Pharmac	y benefits.		
Physician Office Services										
Primary Care Provider										
,	\$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%
<b>Preventive Care:</b> Primary Care Provider or Specialist	0%	20% After Deductible	0%	30% After Deductible	0%	30% After Deductible	0%	30% After Deductible	0%	30% After Deduc
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Prescription Drugs In-Network- One copayment	Tier 1 \$10 copay		Tier 1 \$10 copay		Tier 1 \$10 copay		Tier 1 \$10 copay		Tier 1 \$10 copay	
for 30 day supply	Tier 2 \$35 copay Tier 3 \$55 copay Tier 4 25% \$150 maximum		Tier 2 \$35 copay Tier 3 \$55 copay Tier 4 25% \$150 maximum		Tier 2 \$35 copay Tier 3 \$55 copay Tier 4 25% \$150 maximum		Tier 2 \$40 copay Tier 3 \$65 copay Tier 4 25% \$150 maximum		Tier 2 \$40 copay Tier 3 \$65 copay Tier 4 25% \$150 maximur	
Tot 30 day supply										
<b>PREVENTIVE PHARMACY MED</b> Vitamin D, Folic Acid, Iron Suppled Fluoride.	ICATIONS: A pre.	scription is requi	ired in order to re	eceive the followin	ng medications at i	no cost to you- s	pecific dosage & b	rand may apply:	Aspirin for Cardio	ascular Disea
Urgent Care Center	\$50 copay		\$50 copay		\$60 copay		\$65 copay		\$75 copay	
Emergency Room	\$ <b>250</b> copay		\$250 copay		\$250 copay		\$ <b>250</b> copay		\$ <b>250</b> copay	
Ambulance Services	0% after d	leductible	10% after	deductible	20% after	deductible	30% after	deductible	40% after	deductible
Hospital & Outpatient Services Hospital & Outpatient Clinical	0%	20%	10%	30%	20%	40%	30%	50%	40%	50%
services										
Professional Services Outpatient Labs & Mammograms	0%	20%	10%	30%	20%	40%	30%	50%	40%	50%
with surgery or other services	0% after Dec	20%	10%	30% eductible	20% after De	40%	30% after De	50%	40% after De	50%
Outpatient Labs or Mammograms								ductible	0%	40%
without surgery or other services when performed alone	0% 20 deductible	% No after Deductible	0% 3 deductible	0% No after Deductible	0% 30 deductible	)% No after Deductible	0% 30 deductible	)% No after Deductible	No deductible Deduction	a
Maternity	<b>450</b>	200/	<b>450</b>	200/	460	400/	+c=	500/	475	. 500/
Office (Copay may apply) Hospital Services (Delivery)	\$50 copay 0%	20% 20%	\$50 copa	ay 30% 30%	\$60 copa 20%	y 40% 40%	\$65 copa 30%	y 50% 50%	\$75 copa 40%	y 50% 50%
Professional Services (Delivery)		20%	10%	30%	20%	40% 40%	30%	50% 50%	40%	50% 50%
. Totassional Scivices (Delivery)	after Dec			eductible		eductible	after De		after De	
Rehab & Habilitative	5.cc. 5cc		u. tc. D		G. 10. De		G. 10. DC		u. tc. De	
Therapies (30 Visit Limit)										
·	\$50 copay	20%	\$50 copay	30%	\$60 copay	40%	\$65 copay	50%	\$75 copay	50%

The deductible **must be met** before the coinsurance percentages are applied (excluding tier 4 drugs).

20%

\$60 copay

20%

\$35 copay

20%

yes

ves

after Deductible

after Deductible

at participating providers

after Deductible

40%

40%

40%

Not Covered

40%

no

no

30%

\$65 copay

30%

\$40 copay

30%

yes

Ves

after Deductible

after Deductible

at participating providers

after Deductible

50%

50%

50%

Not Covered

no

no

50%

40%

\$75 copay

40%

\$45 copay

yes

after Deductible

after Deductible

at participating providers

after Deductible

50%

50%

50%

Not Covered

no

no

50%

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.

Skilled Nursing Facility (60 days per benefit period)

Mental Health Services & Substance Abuse

Comprehensive Eye Exam

15% Disposable Contacts Discount

30% Lens & Frame Discount

Home Health Care, Hospice, Durable Medical

Inpatient/Outpatient

Vision Care

Equipment

Office

0%

\$50 copay

0%

yes

ves

20%

20%

20%

no

no

20%

after Deductible

after Deductible

at participating providers

\$30 copay Not Covered

after Deductible

10%

\$50 copay

10%

\$30 copay

10%

yes

Ves

after Deductible

after Deductible

at participating providers

after Deductible

30%

30%

30%

Not Covered

no

no

30%

## 10-01-2016 to 9-30-2017 NORTH CAROLINA BAR ASSOCIATION HEALTH BENEFIT TRUST PROPOSED COMPARISON OF BENEFITS

This illustration is for Benefits Highlights only

See separate SBC's and Member Guides for additional information and special provisions

Deductible per Plan Year  With all High-Deductible Plans, the Deductible must be met before any benefits are paid Preventive Care)  **For family coverage, family deductible must be met before coinsurance is applied*  Employee  Family (Employee +1 or more)  Total Out of Pocket Maximum (Includes Deductible)  Employee  \$3,250 \$6,500 \$3,500 \$7,000 \$14,000 \$1  Employee +1 or more)  \$3,250 \$6,500 \$3,500 \$7,000 \$14,000 \$1  Unlimited  Unlimited	ERED BENEFITS	BLUE O	PTIONS	BLU	E OPTIONS	BLUE OPTIONS HDHP Plan 20 HSA Eligible		
In-Network Out-of Network In-Network Out-of-Network In-Network Out-of-Network In-Network In-Network Out-of-Network In-Network In-Network Out-of-Network In-Network Out-of-Network In-Network In-Network Out-of-Network In-Network In-Network Out-of-Network In-Network In-Network Out-of-Network In-Network In-Network In-Network In-Network Out-of-Network In-Network In-Network In-Network In-Network Out-of-Network In-Network In-Ne		HDHP I	Plan 10	HD	HP Plan 15			
Deductible per Plan Year  With all High-Deductible Plans, the Deductible must be met before any benefits are paid Preventive Care)  *For family coverage, family deductible must be met before coinsurance is applied*  Employee  Family (Employee +1 or more)  Total Out of Pocket Maximum (Includes Deductible)  Employee  Family (Employee +1 or more)  \$3,250 \$6,500 \$33,500 \$7,000 \$14,000 \$1  Employee  \$3,250 \$6,500 \$33,500 \$7,000 \$5  Employee  Family (Employee +1 or more)  Unlimited  Unlimited		HSA E	ligible	Н	SA Eligible			
#In 2016, the out-of-pocket maximum can be no more than \$6,850 for an individual participating in the family coverage, family deductible must be met before coinsurance is applied*  Employee \$1,750 \$3,500 \$3,500 \$7,000 \$\$  Family (Employee +1 or more) \$3,500 \$7,000 \$\$  *In 2016, the out-of-pocket maximum can be no more than \$6,850 for an individual participating in the family annually. In 2017, the out-of-pocket maximum can be no more than \$7,150 for an individual participating in the family annually. In 2017, the out-of-pocket maximum can be no more than \$7,150 for an individual participating in the family annually. In 2017, the out-of-pocket maximum can be no more than \$7,150 for an individual participating in the family annually. In 2017, the out-of-pocket maximum can be no more than \$6,850 for an individual participating in the family annually. In 2017, the out-of-pocket maximum can be no more than \$6,850 for an individual participating in the family annually. In 2017, the out-of-pocket maximum can be no more than \$6,850 for an individual participating in the family annually. In 2017, the out-of-pocket maximum can be no more than \$6,850 for an individual participating in the family annually. In 2017, the out-of-pocket maximum can be no more than \$6,850 for an individual participating in the family annually. In 2017, the out-of-pocket maximum can be no more than \$7,150 for an individual participating in the family annually. In 2017, the out-of-pocket maximum can be no more than \$6,850 for an individual participating in the family annually. In 2017, the out-of-pocket maximum can be no more than \$7,150 for an individual participating in the family annually. In 2017, the out-of-pocket maximum can be no more than \$7,100 \$\$  **In 2016, the out-of-pocket maximum can be no more than \$7,100 \$\$  **In 2016, the out-of-pocket maximum can be no more than \$7,100 \$\$  **In 2016, the out-of-pocket maximum can be no more than \$7,100 \$\$  **In 2016, the out-of-pocket maximum can be no more than \$7,100 \$\$  **In 2016, the out-of-	Ir	In-Network Out-o	of Network	In-Network (	Out-of-Network	In-Network	Out-of-Network	
must be met before coinsurance is applied*         the family annually. In 2017, the out-of-pocket maximum can be no more than \$7,150 for an individed and \$14,300 for the family annually.*           Employee         \$1,750         \$3,500         \$7,000         \$7,000         \$1           Family (Employee +1 or more)         \$3,500         \$7,000         \$14,000         \$1           Total Out of Pocket Maximum (Includes Deductible)         \$3,250         \$6,500         \$3,500         \$7,000         \$5           Employee         \$3,250         \$6,500         \$3,500         \$7,000         \$5           Family (Employee +1 or more)         \$6,500         \$13,000         \$7,000         \$14,000         \$1           Lifetime Maximum         Unlimited         Unlimited         Unlimited	uctible per Plan Year	, , ,						
Family (Employee +1 or more)       \$3,500       \$7,000       \$14,000       \$1         Total Out of Pocket Maximum (Includes Deductible)         Employee       \$3,250       \$6,500       \$3,500       \$7,000       \$5         Family (Employee +1 or more)       \$6,500       \$13,000       \$7,000       \$1         Lifetime Maximum       Unlimited       Unlimited	must be met before coinsurance is	*In 2016, the out-of-pocket maximum can be no more than \$6,850 for an individual participating in a family plan and \$13,700 for the family annually. In 2017,the out-of-pocket maximum can be no more than \$7,150 for an individual participating in a family plan and \$14,300 for the family annually.*						
\$3,500 \$7,000 \$7,000 \$14,000 \$1   Total Out of Pocket Maximum (Includes Deductible)	loyee	\$1,750	\$3,500	\$3,500	\$7,000	\$5,0	97,000	
(Includes Deductible)         \$3,250         \$6,500         \$3,500         \$7,000         \$5           Employee         \$6,500         \$13,000         \$7,000         \$14,000         \$1           Lifetime Maximum         Unlimited         Unlimited         Unlimited	ily (Employee +1 or more)	\$3,500	\$7,000	\$7,000	\$14,000	\$10,0	914,000	
Family (Employee +1 or more)         \$6,500         \$13,000         \$7,000         \$14,000         \$1           Lifetime Maximum         Unlimited         Unlimited								
Lifetime Maximum Unlimited Unlimited	loyee	\$3,250	\$6,500	\$3,500	\$7,000	\$5,00	00 \$10,000	
	ily (Employee +1 or more)	\$6,500	\$13,000	\$7,000	\$14,000	\$10,0	00 \$20,000	
Proventive Care 0% 30% 0% 30%	time Maximum	Unlimite	ed	Unlin	nited	Unl	imited	
1070   1070	ventive Care	0%	30%	0%	30%	00	% 30%	
After Deductible After Deductible			After Deductible		After Deductible		After Deductible	

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 Screening, 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.

II		=			
Physician Office Services					
Primary Care Provider or Specialist	20% 40% after Deductible	0% 20% after Deductible	0% 30% after Deductible		
Hospital & Outpatient Services Hospital & Outpatient Clinical Professional Services	20% 40% 20% 40%	0% 20% 0% 20%	0% 30% 0% 30%		
Outpatient X-rays & Labs	20% 40% after Deductible	0% 20% after Deductible	0% 30% after Deductible		
Maternity	20% 40% after Deductible	0% 20% after Deductible	0% 30% after Deductible		
Home Health Care, Hospice, Durable Medical Equipment	20% 40% after Deductible	0% 20% after Deductible	0% 30% after Deductible		
Mental Health Services					
Office Inpatient/Outpatient	20% 40% 20% 40% after Deductible	0% 20% 0% 20% after Deductible	0% 30% 0% 30% after Deductible		
Rehab & Habilitative Therapies	20% 40%	0% 20%	0% 30%		
(30 Visit Limit)	after Deductible	after Deductible	after Deductible		
Skilled Nursing Facility (60	20% 40%	0% 20%	0% 30%		
days/period)	after Deductible	after Deductible	after Deductible		
Substance Abuse Services					
Office & Inpatient/Outpatient	20% 40% after Deductible	0% 20% after Deductible	0% 30% after Deductible		
Urgent Care Center &	20% 20%	0% after deductible	0% after deductible		
Emergency Room	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	Deductible (if applicable) +Co-Insurance	Deductible (if applicable) +Co-Insurance	Deductible (if applicable) +Co-Insurance		
Out-of-Network	+ Charge Over In-Network Allowed Amount	+ Charge Over In-Network Allowed Amount	+ Charge Over In-Network Allowed Amount		
Vision Care	at participating providers	at participating providers	at participating providers		
Comprehensive Eye Exam	20% 40% after Deductible	0% 20% after Deductible	0% 30% after Deductible		
30% Lens & Frame Discount	yes no	yes no	yes no		
15% Disposable Contacts Discount	yes no	yes no	yes no		

The Total Out of Pocket Maximum includes the Deductible.