Blue Options℠ Benefit Highlights (PPO)

The coinsurance amounts that appear on this benefit highlight represent Plan responsibility. The coinsurance amounts that display in the benefit booklet represent member responsibility.

	In-network	Out-of-network[1]
Physician Office Services *(See "Hospital Based Clinics" for "outpatient clinic" or "hospital-based" services.)*		
Office Visit *Includes Office Surgery, Consultation, X-rays and Labs, and a benefit period maximum of 4 office visits for the evaluation and treatment of obesity in and out-of-network. See "Inpatient and Outpatient Services".*		
Primary Care Provider	$20 copayment	70% after deductible
Specialist	$40 copayment	70% after deductible
Preventive Care *(Primary Preventative Diagnosis Only)* *Routine Examinations, Well-Child Care, Well-Baby Care, Immunizations, Well-Woman Care, colorectal screening, bone mass measurement, newborn hearing screening, routine eye exam and prostate specific antigen tests (PSAs).*		
Primary Care Provider	100%, no deductible	Not Available*
Specialist	100%, no deductible	Not Available*
**Colorectal screening, bone mass measurement, newborn hearing screening, prostate specific antigen tests (PSAs) and certain well woman care like gynecological exams, cervical cancer screening, ovarian cancer screening and screening mammograms are covered Out-of-network.*		
Therapies *Short-term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings): Physical/Occupational: 30 visits per Benefit Period;Speech Therapy: 30 visits per Benefit Period*		
Primary Care	$20 copayment	70% after deductible
Specialist	$40 copayment	70% after deductible
Urgent Care Centers and Emergency Room		
Urgent Care Centers	$40 copayment	$40 copayment
Emergency Room Visit	$300 copayment	$300 copayment
(Inpatient Hospital benefits apply if admitted. If held for observation, outpatient benefits apply. See "Inpatient and Outpatient Hospital Services".)		
Ambulatory Surgical Center	80% after deductible	70% after deductible
Inpatient and Outpatient Hospital Services		
Hospital and Hospital Based Services	80% after deductible	70% after deductible
Hospital Based Clinics(other than preventive services above)	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible
Outpatient Diagnostic Services		
Outpatient Labs and Mammograms with surgery or other services.	80% after deductible	70% after deductible
Outpatient Labs and Mammograms without surgery or other services.	100%	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEG's and EKG's	80% after deductible	70% after deductible
CT scans, MRI 's, MRA's and PET scans in any location, including physician's office	80% after deductible	70% after deductible
Other Services		
Skilled Nursing Facility *(60 days per Benefit Period)*	80% after deductible	70% after deductible
Home Health Care, Durable Medical Equipment and Hospice	80% after deductible	70% after deductible
Ambulance	80% after deductible	80% after deductible
Maternity *Maternity Delivery includes Prenatal and Post-delivery care*		
Hospital Services *(Delivery)*	80% after deductible	70% after deductible
Professional Services *(Delivery)*	80% after deductible	70% after deductible
Transplants		
Hospital Services	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible
Infertility Services (Up to $5,000 per Lifetime)		
Primary Care Provider	$20 copayment	70% after deductible
Specialist	$40 copayment	70% after deductible
Hospital Services	80% after deductible	70% after deductible
Inpatient and Outpatient Professional Services	80% after deductible	70% after deductible
Vision Care		
Comprehensive Eye Exam (Non-preventive/Diagnostic)	$40 copayment	70% after deductible

Blue Options[SM] Benefit Highlights (PPO)

Lifetime Maximum, Deductibles & Coinsurance Maximums	In-network	Out-of-network [1]
The following Deductibles and Coinsurance Maximums only apply to the services on the previous page and Mental Health and Substance Abuse services below:		
Lifetime Benefit Maximum	Unlimited	Unlimited
Deductibles		
Individual *(per Benefit Period)*	$2,500	$5,000
Family *(per Benefit Period)*	$5,000	$10,000
Coinsurance Maximum		
Individual *(per Benefit Period)*	$2,000	$4,000
Family *(per Benefit Period)*	$4,000	$8,000

Mental Health and Substance Abuse Services				
Mental Health Services				
Office Visit	$40	copayment	70%	after deductible
Inpatient/Outpatient	80%	after deductible	70%	after deductible
Substance Abuse Services				
Office Visit	$40	copayment	70%	after deductible
Inpatient/Outpatient	80%	after deductible	70%	after deductible

Prescription Drugs			
Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments. Infertility Drugs up to $5,000 Lifetime Maximum. MAC B Pricing (Brand Penalty when Generic Equivalent is available and Provider does not require Brand to be dispensed). Penalty does not count toward OOP Limit. Enhanced Formulary. Prior Plan approval, step therapy and quantity limits may apply.			
Generic	$10	copayment	Copayment + charge over In-network allowed amount
Brand Drugs	50%	coinsurance	Coinsurance + charge over In-network allowed amount
There is a $100 per Drug Maximum, for each 30-day supply of Brand drugs			

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 BCBSNC and its members.

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ADDITIONAL INFORMATION ABOUT BLUE OPTIONS FROM BCBSNC

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 BCBSNC. A charge shall be considered incurred on the date the service or supply was provided to a member.

Allowed Amount
The maximum amount that BCBSNC determines is to be paid for covered services provided to a member.

Coinsurance Maximum
The dollar amount of coinsurance a member must pay prior to BCBSNC paying 100% for certain services.

NOTE: In some plans, there is no coinsurance maximum; members are responsible for coinsurance once the deductible has been met.

Day and Visit Maximums
All day and visit maximums are on a combined In- and Out-of Network basis.

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. If you would like a copy of a benefit booklet providing more information about our Utilization Management programs, call the toll free number listed in your information packet.

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, a penalty will be applied.

For maternity admissions, your provider is not required to obtain certification from BCBSNC 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 BCBSNC, if medically necessary.

All inpatient and certain outpatient Mental Health and Substance Abuse services must be certified in advance by Magellan Behavioral Health. Call Magellan Behavioral Health at 1-800-359-2422. Office visits do not require certification.

In-network providers are responsible for obtaining certifications. The member will bear no financial penalties if the in-network provider fails to obtain the appropriate authorization. The member is responsible for obtaining certification for services rendered by an out-of-network or out-of-state provider.

Health and Wellness Program
Because we want to help you stay healthy, we offer a variety of wellness benefits and services. You can take advantage of HealthLine Blue, our 24-hour health information service, a health topics library, asthma and diabetes management and a prenatal program. You will also have access to online health and wellness information at www.bcbsnc.com. With our program you can get health advice anytime you need it, so you can learn how to 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 treatment of sexual dysfunction not related to organic disease
- For conception by artificial means
- For self-injectable drugs in the provider's office

A waiting period for coverage of pre-existing conditions may apply to your coverage. Pre-existing conditions are those conditions for which medical advice, diagnosis, care or treatment was received or recommended within 6 months of the date that your BCBSNC coverage begins. You may receive credit toward the 12-month waiting period if your enrollment date is within 63 days of the termination of your previous health coverage.