BCBS Medical Plan - Summary of Benefits

Benefit period— July 1, 2008 through June 30, 2009
Benefit payments are based on where the services are received and how the services are billed.

	In-network	**Out-of-network***
Physician Office Services		

See Outpatient Services for outpatient clinic or hospital based services. Office visits for the evaluation and treatment of obesity are limited to a combined in-and out-of-network maximum of four visits per benefit period.

	In-network	Out-of-network*
Office Services		
Primary Care Provider	$20 copayment	70% after ded
Specialist	$40 copayment	70% after ded

Includes office surgery, x-rays and lab tests.

CT Scans, MRIs, MRAs and PET Scans	80% after ded	70% after ded

	In-network	Out-of-network*
Preventive Care		
Primary Care Provider	100%	Benefits not available
Specialist	100%	Benefits not available

Includes routine physical exams, well baby, well-child care, and immunizations. The following preventive care benefits are available out-of-network: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, and prostate specific antigen tests. See “Covered Services.”

	In-network	Out-of-network*
Short-term Rehabilitative Therapies	$40 copayment	70% after ded
Chiropractic Services	$20 copayment	70% after ded

Combined in- and out-of-network benefit period maximums apply to home, office and outpatient settings. 30 visits per benefit period for physical/occupational therapy, including chiropractic services. 30 visits per benefit period for speech therapy.

	In-network	Out-of-network*
Other Therapies	100%	70% after ded

Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See Outpatient Services for other therapies provided in an outpatient setting.

	In-network	Out-of-network*
Infertility and Sexual Dysfunction Services		
Primary Care Provider	$20 copayment	70% after ded
Specialist	$40 copayment	70% after ded

Combined in- and out-of-network lifetime maximum of $5,000 per member, provided in all places of service.

	In-network	Out-of-network*
Routine Eye Exam	$20 copayment	Benefits not available

**The following notice applies only when you go to an out-of-network provider.*
NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or copayment amount because actual provider charges may not be used to determine the Plan’s and member’s payment obligations. For out-of-network benefits, you may be required to pay for charges over the allowed amount, in addition to any copayment or coinsurance amount.

	In-network	**Out-of-network***
Urgent Care Centers and Emergency Room		
Urgent Care Centers	$40 copayment	$40 copayment
Emergency Room Visit	$150 copayment	$150 copayment

If admitted to the hospital from the emergency room, inpatient hospital benefits apply to all covered services provided. If held for observation, outpatient benefits apply to all covered services provided. If you are sent to the emergency room from an Urgent Care Center, you may be responsible for both the emergency room copayment and the urgent care copayment.

Ambulatory Surgical Center	80% after ded	70% after ded

Outpatient Services		
Physician Services	80% after ded	70% after ded
Hospital & Hospital-based Services	80% after ded	70% after ded
Outpatient Clinic Services	80% after ded	70% after ded
Outpatient Diagnostic Services:		
Outpatient lab tests and mammography, when performed alone	100%	70% after ded
Outpatient lab tests and mammography, when performed with another service	80% after ded	70% after ded
Outpatient xrays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	80% after ded	70% after ded
CT scans, MRIs, MRAs and PET scans	80% after ded	70% after ded
Therapy Services	80% after ded	70% after ded

Includes short-term rehabilitative therapies and other therapies including dialysis; see Physician Office Services for visit maximums.

Inpatient Hospital Services		
Physician Services	80% after ded	70% after ded
Hospital and Hospital-based Services	80% after ded	70% after ded

Includes maternity delivery, prenatal and post-delivery care.

Skilled Nursing Facility	80% after ded	70% after ded

Combined in- and out-of-network maximum of 60 days per benefit period. Services applied to the deductible count towards this day maximum.

Other Services	80% after ded	70% after ded

Includes ambulance, durable medical equipment, hospice services, medical supplies, orthotic devices, private duty nursing, prosthetic appliances, and home health care. Orthotic devices for correction of positional plagiocephaly are limited to a lifetime maximum of $600.

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	In-network	Out-of-network*

Lifetime Maximum, Deductible, and Coinsurance Maximum

The following deductibles and maximums apply to the services listed above in the "Summary Of Benefits" unless otherwise noted.

Lifetime Maximum	$5,000,000	$5,000,000

Limited to a combined in- and out-of-network lifetime maximum per member.

Deductible

Individual, per benefit period	$500	$1,000
Family, per benefit period	$1,500	$3,000

Charges for the following do not apply to the benefit period deductible:

• inpatient newborn care for well baby
• mental health and substance abuse services
• prescription drugs

Coinsurance Maximum

Individual, per benefit period	$2,000	$4,000
Family, per benefit period	$6,000	$12,000

Charges for the following do not apply to the benefit period coinsurance maximum:

• mental health and substance abuse services
• prescription drugs

Penalty For Failure To Obtain Certification

Certain services require prior review and certification by BCBSNC in order to receive benefits. If you go to an in-network provider in North Carolina, your provider will request prior review when necessary. If you go to an out-of-network provider in North Carolina or to any provider outside of North Carolina, you are responsible for requesting or ensuring that your provider requests prior review by BCBSNC. **Failure to request prior review and receive certification may result in allowed charges being reduced by 25% or a full denial of benefits. See "Covered Services" and "Prospective Review/Prior Review" in "Utilization Management."**

Prescription Drugs

Generic Drugs Tier 1	$10 copayment	$10 copayment
Preferred Brand Name Drugs Tier 2	$35 copayment	$35 copayment
Brand Name Drugs Tier 3	$50 copayment	$50 copayment
Diabetic Supplies	75%	75%
Spacers and Peak Flow Meters	75%	75%

One copayment for up to a 30-day supply. 31-90-day supply is two and one half copayments. Please refer to *"Prescription Drugs"* in *"Covered Services"* for more information. *Infertility drugs* are limited to a combined in- and out-of-network lifetime maximum of $5,000 per member**.**

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	In-network	Out-of-network*

Mental Health And Substance Abuse Services

Prior review and certification by Magellan Behavioral Health are required only for in-patient and outpatient services received from an in-network provider. Please see the number in “Whom Do I Call?”

	In-network	Out-of-network*
Mental Health Office Services	$40 copayment	70%

Combined in- and out-of-network limit of: 20 office visits per benefit period.

	In-network	Out-of-network*
Mental Health Inpatient/ Outpatient Services	80%	70%

Combined in- and out-of-network limit of 30 days per benefit period.

	In-network	Out-of-network*
Substance Abuse Office Services	$40 copayment	70%
Substance Abuse Inpatient/ Outpatient Services	80%	70%

Substance Abuse Benefit Period Maximum $8,000

Substance Abuse Lifetime Maximum $16,000

**The following notice applies only when you go to an out-of-network provider. NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or copayment amount because actual provider charges may not be used to determine the Plan’s and member’s payment obligations. For out-of-network benefits, you may be required to pay for charges over the allowed amount, in addition to any copayment or coinsurance amount.*

What is not Covered

Exclusions that are specific to a type of service are stated along with the benefit description in “Covered Services.” Exclusions that apply to many services are listed in this section. To understand all of the exclusions that apply, read “Covered Services,” “Summary Of Benefits” and “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.

• Not medically necessary

• Investigational in nature or obsolete, including any service, drugs, procedure or treatment directly related to an investigational treatment

• Any experimental drug or any drug not approved by the Food and Drug Administration (FDA) for the applicable diagnosis or treatment. However, this exclusion does not apply to prescription drugs used in covered phases II, III and IV clinical trials, or drugs approved by the FDA for treatment of cancer, if prescribed for the
treatment of any type of cancer for which the drug has been approved as effective in any one of the three nationally recognized drug reference guides:

1. The American Medical Association Drug Evaluations
2. The American Hospital Formulary Service Drug Information
3. The United States Pharmacopoeia Drug Information.

• Side effects and complications of non-covered services, except for emergency services in the case of an emergency

• Not prescribed or performed by or upon the direction of a doctor or other provider

• For any condition, disease, illness or injury that occurs in the course of employment, if the employee, employer or carrier is liable or responsible (1) according to a final adjudication of the claim under a state’s workers’ compensation laws, or (2) by an order of a state Industrial Commission or other applicable regulatory agency approving a settlement agreement

- For a health care professional to administer injectable prescription drugs which can be self-administered, unless medical supervision is required
- For inpatient admissions primarily for the purpose of receiving diagnostic services or a physical examination. Inpatient admissions primarily for the purpose of receiving therapy services are excluded except when the admission is a continuation of treatment following care at an inpatient facility for an illness or accident requiring therapy.
- For care in a self-care unit, apartment or similar facility operated by or connected with a hospital
- For custodial care, domiciliary care or rest cures, care provided and billed for by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments, in residential treatment facilities, except for substance abuse treatment, or any similar facility or institution
- For respite care except as specifically covered by the Plan
- Received prior to the member's effective date
- Received after the coverage termination date, regardless of when the treated condition occurred, and regardless of whether the care is a continuation of care received prior to the termination

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WHOM DO I CALL?

BCBSNC Web Site
To view your claims, get Plan information, claim forms, health and wellness information, drug formulary updates, find a doctor, change your address, and request new ID cards, visit the BCBSNC Web site: **bcbsnc.com**

BCBSNC Customer Services
For questions about your benefits or claims, ID card requests, or to voice a complaint:
BCBSNC Customer Services . . . . 1-877-258-3334 (toll free)

Mental Health And Substance Abuse Services
Companies who have signed contracts with BCBSNC administer these benefits. You must contact these vendors directly and request prior review for inpatient and outpatient services, except for office visit services and in emergencies. In the case of an emergency, please notify the vendor as soon as reasonably possible:
Magellan Behavioral Health . . . . 1-800-359-2422 (toll free)

Out Of North Carolina Care
For help obtaining care outside of North Carolina and outside of the U.S., visit the national BCBS Web site at **bcbs.com** or call:
BluePCard PPO Program. . . . . 1-800-810-BLUE (2583) (toll free)

HealthLine Blue SM
To receive confidential, up-to-date health information 24 hours a day from specially trained nurses:
HealthLine Blue . . . . 1-877-477-2424 (toll free)

COBRA Administrator
Interactive Medical Systems (IMS) . . . . 1-800-426-8739 (toll free)

Prior Review
Some services require *prior review and certification* by *BCBSNC.* The list of these services may change from time to time. Please visit the *BCBSNC* Web site at **bcbsnc.com** or call *BCBSNC* Customer Services at the number given above for current information about which services require *prior review*. See "Prospective Review/*Prior Review"* in *"Utilization Management"* for information about the review process. To request *prior review,* call:
Providers . . . . 1-800-214-4844 (toll free)
Members . . . . 1-877-258-3334 (toll free)

The benefit highlights is a summary of BCBSNC benefits. This is meant only to be a summary. Final interpretation and a complete listing of benefits and what is not covered are in and governed by the group contract and benefit booklet. You may preview the benefit booklet by requesting a copy of the BCBSNC benefit booklet from BCBSNC Customer Services.

BASE RATES ***WITHOUT*** HEALTH RISK ASSESSMENT / BIOMETRICS

	MONTHLY RATES	PER PAY PERIOD RATES
Employee Only	$51.00	$25.50
Employee + Child	$157.00	$78.50
Employee + Children	$254.00	$127.00
Employee + Spouse	$241.00	$120.50
Employee + Family	$326.00	$163.00

DISCOUNTED RATES ***WITH*** HEALTH RISK ASSESSMENT / BIOMETRICS

	MONTHLY RATES	PER PAY PERIOD RATES
Employee Only	$21.00	$10.50
Employee + Child	$127.00	$ 63.50
Employee + Children	$224.00	$112.00
Employee + Spouse	$211.00	$105.50
Employee + Family	$296.00	$148.00

FOR CLAIMS/CUSTOMER SERVICE
PLEASE CALL: 1-877-258-3334
website address: www.bcbsnc.com