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## BCBS Medical Plan - Summary of Benefits

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Benefit period - July 1, 2009 through June 30, 2010

Benefit payments are based on where the services are received and how the services are billed.

	In-network	Out-of-network*
<b>Physician Office Services</b>		
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.		
<u>Office Services</u>		
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
<u>Preventive Care</u>		
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."		
<u>Short-term Rehabilitative Therapies</u>		
Chiropractic Services	\$40 copayment	70% after ded
	\$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.		
<u>Other Therapies</u>	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.		
<u>Infertility and Sexual Dysfunction Services</u>		
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.		
<u>Routine Eye Exam</u>	\$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.*

	<b>In-network</b>	<b>Out-of-network*</b>
<u><b>Urgent Care Centers and Emergency Room</b></u>		
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.		
<u><b>Ambulatory Surgical Center</b></u>	80% after ded	70% after ded
<u><b>Outpatient Services</b></u>		
<i>Physician Services</i>	80% after ded	70% after ded
<i>Hospital &amp; Hospital-based Services</i>	80% after ded	70% after ded
<i>Outpatient Clinic Services</i>	80% after ded	70% after ded
<i>Outpatient Diagnostic Services:</i>		
<i>Outpatient lab tests and mammography, when performed alone</i>	100%	70% after ded
<i>Outpatient lab tests and mammography, when performed with another service</i>	80% after ded	70% after ded
<i>Outpatient xrays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests</i>	80% after ded	70% after ded
<i>CT scans, MRIs, MRAs and PET scans</i>	80% after ded	70% after ded
<i>Therapy Services</i>	80% after ded	70% after ded
Includes short-term rehabilitative therapies and other therapies including dialysis; see Physician Office Services for visit maximums.		
<u><b>Inpatient Hospital Services</b></u>		
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.		
<u><b>Skilled Nursing Facility</b></u>	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.		
<u><b>Other Services</b></u>	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.

<u>Lifetime Maximum</u>	\$5,000,000	\$5,000,000
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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

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**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."**

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**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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	<b>In-network</b>	<b>Out-of-network*</b>
<b><u>Mental Health And Substance Abuse Services</u></b>		
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?"		
<u>Mental Health Office Services</u>	\$40 copayment	70%
Combined in- and out-of-network limit of: 20 office visits per benefit period.		
<u>Mental Health Inpatient/ Outpatient Services</u>	80%	70%
Combined in- and out-of-network limit of 30 days per benefit period.		
<u>Substance Abuse Office Services</u>	\$40 copayment	70%
<u>Substance Abuse Inpatient/ Outpatient Services</u>	80%	70%
<u>Substance Abuse Benefit Period Maximum</u>		\$8,000
<u>Substance Abuse Lifetime Maximum</u>		\$16,000

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**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

***For a more detailed list of exclusions, please refer to your BCBS member guide.***

**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:

BlueCard PPO Program. . . . . 1-800-810-BLUE (2583) (toll free)

**HealthLine Blue<sup>SM</sup>**

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**

	<u>MONTHLY RATES</u>	<u>PER PAY PERIOD RATES</u>
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**

	<u>MONTHLY RATES</u>	<u>PER PAY PERIOD RATES</u>
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](http://www.bcbsnc.com)**