
Blue Cross Blue Shield PPO Health Plan

Effective Date: August 1, 2010

BENEFIT HIGHLIGHTS

| | <u>In-Network</u> | <u>Out-of-Network¹</u> |
|---|--------------------------|--|
| Physician Office Services (See <i>Outpatient Clinic Services</i> , for “outpatient clinic” or “hospital-based” services) | | |

Office Visit

Includes Office Surgery, Consultation, X-rays and Lab, and a benefit period maximum of 4 office visits for the assessment of obesity in and out of network.

| | | |
|-----------------------|----------------------|----------------------|
| Primary Care Provider | \$25 copayment | 70% after deductible |
| Specialist | 80% after deductible | 70% after deductible |

Preventive Care

*Routine Examinations, Well-ChildCare, Immunizations, Pap Smears, Mammograms
Prostate Specific Antigen Tests (PSAs)*

| | | |
|-----------------------|---------------------|----------------|
| Primary Care Provider | 100%, no deductible | Not Available* |
| Specialist | 100%, no deductible | Not Available* |

**Pap Smears, Mammograms, and PSAs 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

Chiropractic Therapy: 30 visits limit per Benefit Period

| | | |
|--------------|----------------------|----------------------|
| Primary Care | \$25 copayment | 70% after deductible |
| Specialist | 80% after deductible | 70% after deductible |

Urgent Care Centers and Emergency Room

| | | |
|---------------------|----------------------|----------------------|
| Urgent Care Centers | 80% after deductible | 80% after deductible |
|---------------------|----------------------|----------------------|

| | | |
|----------------------|----------------------|----------------------|
| Emergency Room Visit | 80% after deductible | 80% after deductible |
|----------------------|----------------------|----------------------|

Emergency Room Visit- (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 & Hospital Based Services | 80% after deductible | 70% after deductible |
|------------------------------------|----------------------|----------------------|

| | In-network | Out-of-Network |
|---|----------------------|------------------------|
| Outpatient Clinic Services | 80% after deductible | 70% after deductible |
| Professional Services | 80% after deductible | 70% after deductible |
| Hospital & Professional | | |
| Outpatient Labs & Mammograms with surgery or other services | 80% after deductible | 70% after deductible |
| Outpatient Labs & 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 |
| <hr/> | | |
| Other Services | | |
| Skilled Nursing Facility (<i>60 days per Benefit Period</i>) | 80% after deductible | 70% after deductible |
| Home Health Care, Ambulance, Durable Medical Equipment & Hospice | | |
| | 80% after deductible | 70% after deductible |
| Maternity (<i>Maternity Delivery includes Prenatal & Post-delivery care</i>) | | |
| 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 <i>(Up to \$5,000)</i> | | |
| Primary Care Provider | \$25 copayment | 70% after deductible |
| Specialist | 80% after deductible | 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 | 100%, no deductible | Benefits not available |

Lifetime Maximum, Deductibles, & Coinsurance Maximums

The following Deductibles and Coinsurance Maximums only apply to the services on the previous page and (Mental Health and Substance Abuse services below):

| | In-network | Out-of-network¹ |
|---------------------------------|-------------------|-----------------------------------|
| Lifetime Benefit Maximum | \$5,000,000 | \$5,000,000 |
| Deductibles | | |
| Individual (per Benefit Period) | \$1,250 | \$2,500 |
| Family (per Benefit Period) | \$3,750 | \$7,500 |
| Coinsurance Maximum | | |
| Individual (per Benefit Period) | \$2,000 | \$4,000 |
| Family (per Benefit Period) | \$6,000 | \$12,000 |

Mental Health and Substance Abuse Services

*Inpatient /Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422

Mental Health Services

| | | |
|------------|----------------------|----------------------|
| Office | 80% after deductible | 70% after deductible |
| Inpatient | 80% after deductible | 70% after deductible |
| Outpatient | 80% after deductible | 70% after deductible |

Substance Abuse Services

| | | |
|------------|----------------------|----------------------|
| Office | 80% after deductible | 70% after deductible |
| Inpatient | 80% after deductible | 70% after deductible |
| 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. MAC B Pricing, Brand Penalty.

| | | |
|---------------------------------|-----------------|---|
| Tier 1 (Generic) | \$10 copay | Copayment + charge over in-network allowed amount |
| Tier 2 (Preferred Brand) | \$45 copayment | Copayment + charge over in-network allowed amount |
| Tier 3 (Brand) | \$60 copayment | Copayment + charge over in-network allowed amount |
| Tier 4 (Specialty Brand) | 25% coinsurance | Copayment + charge over in-network allowed amount |

There is a \$50 per Drug Minimum and a \$100 per Drug Maximum for each 30-day supply of Tier 4 Specialty Brand drugs.

'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.

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 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 and care management.

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 outpatient Mental Health and Substance Abuse services must be certified in advance by Magellan Behavioral Health. 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 provider. Obtaining certification for Mental health and Substance Abuse services is the member's responsibility.

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 receive Active Blue, our quarterly health magazine and 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
- 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. BCBSNC defines pre-existing conditions as 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.

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

PPO Health Plan

Monthly Rates for Participants (Wellness)

| | |
|-------------------|----------------|
| Employee | Premium Waived |
| Employee & Child | \$170.65 |
| Employee & Family | \$311.20 |

Monthly Rates for Non-Participants (Wellness)

| | |
|---------------------------------|----------|
| Employee (County pays \$650.00) | \$75.00 |
| Employee & Child | \$245.65 |
| Employee & Family | \$386.20 |

For Blue Cross Blue Shield Customer Service please call 1.877.258.3334.



Blue Cross Blue Shield HSA (Health Savings Account)

NOTE: The Health Savings Account (HSA) is established by Robeson County Government. The HSA is administered by Mellon Financial Corporation and is not part of the Blue Options HSA policy.

A Health Savings Account combines traditional medical coverage with a savings account and investment options. You can make tax-free contributions to the savings account up to federal limits.

For 2010, your annual contribution is limited to **\$3,050 for individuals** and **\$6,150 for families**. Limits for future years will be set by the IRS.

If you are age 55 or older, and not enrolled in Medicare, you may make an additional contribution for up to \$1,000 to your HSA in 2010 and later years until you are age 65. Please consult with your tax advisor for further information.

Maximum contributions are based upon maintaining enrollment in a qualified HSA medical plan on the 1st of the month for 12 months of the contract year. For enrollment less than 12 months, you may not be eligible for the maximum contribution. Please consult your tax advisor.

HSA dollars can be used to reimburse yourself for qualified healthcare expenses incurred by you, your spouse or eligible dependents. Qualified expenses include **medical, dental and vision expenses as defined under Section 213(d) of the tax code and include expenses that are not covered by your HSA qualified medical plan.** Qualified dependents are children, siblings, parents and others who are considered an exemption under Section 152 of the tax code.

The plan deductible is the portion of covered medical and pharmacy expenses that you pay before your plan will begin to cover healthcare expenses. Only covered services count toward the plan deductible. Once your plan deductible has been met, your plan begins providing coverage for eligible services as described in the policy. All covered expenses (including those expenses applied to the plan deductible) benefit from negotiated discounts with participating providers and pharmacies.

Any dollars remaining in your savings account at the end of the year carry over to the next year. If you change employers or retire, you may take any dollars in your savings account with you.

You can choose how you pay for medical expenses that are submitted through your qualified HSA medical plan:

- You may pay for medical expenses on a claim-by-claim basis using the debit card that comes with your HSA.
- You may choose to cover your expenses using your own personal funds. This allows you to save your HSA dollars for future years.

Effective Date: August 1, 2010

Health Savings Account Contribution from Robeson County Government- \$750 (annually)

BENEFIT HIGHLIGHTS

| | <u>In-Network</u> | <u>Out-of-Network²</u> |
|--|-------------------|-----------------------------------|
|--|-------------------|-----------------------------------|

Lifetime Maximum, Deductibles, & Total Out of Pocket Maximums
The following Deductibles and Total Out of Pocket Maximums apply to all services unless otherwise indicated:

| | | |
|------------------------------------|-------------|-------------|
| Lifetime Benefit Maximum | \$5,000,000 | \$5,000,000 |
| Deductibles | | |
| Employee (per Benefit Period) | \$1,500 | \$3,000 |
| Family (per Benefit Period) | \$3,000 | \$6,000 |
| Total Out of Pocket Maximum | | |
| Employee (per Benefit Period) | \$3,500 | \$7,000 |
| Family (per Benefit Period) | \$5,000 | \$10,000 |

Physician Office Services

Office Visit

Includes Office Surgery, Consultation, X-rays and Lab, and a benefit period maximum of 4 office visits for the evaluation and treatment of obesity in and out of network.

| | | |
|-------------------------------------|----------------------|----------------------|
| Primary Care Provider or Specialist | 80% after deductible | 50% after deductible |
|-------------------------------------|----------------------|----------------------|

Preventive Care (Preventive Diagnosis Only)

Well-ChildCare (Age 3 and under), Immunizations, Annual Routine Examinations, Pap Smears, Mammograms, Prostate Specific Antigen Tests (PSA's), and other specified screening tests.

| | | |
|-------------------------------------|---------------------|----------------------|
| Primary Care Provider or Specialist | 100%, no deductible | 50% after deductible |
|-------------------------------------|---------------------|----------------------|

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

Chiropractic Therapy: 30 visits per Benefit Period

| | | |
|-------------------------------------|----------------------|----------------------|
| Primary Care Provider or Specialist | 80% after deductible | 50% after deductible |
|-------------------------------------|----------------------|----------------------|

| | <u>In-Network</u> | <u>Out-of-Network²</u> |
|---|----------------------|-----------------------------------|
| Urgent Care Centers and Emergency Room | | |
| Urgent Care Centers | 80% after deductible | 80% after deductible |
| Emergency Room Visit | 80% after deductible | 80% after deductible |
| <hr/> | | |
| Ambulatory Surgical Center | | |
| | 80% after deductible | 50% after deductible |
| <hr/> | | |
| Outpatient Hospital Services <i>(Includes physician services, hospital and hospital-based services, outpatient clinic services, outpatient diagnostic services, and therapy services including short-term rehabilitative therapies and other therapies.)</i> | | |
| | 80% after deductible | 50% after deductible |
| <hr/> | | |
| Inpatient Hospital Services <i>(includes physician services, hospital and hospital-based services, and maternity delivery, prenatal and post-delivery care.)</i> | | |
| | 80% after deductible | 50% after deductible |
| <hr/> | | |
| Other Services | | |
| Skilled Nursing Facility (60 days per Benefit Period) | | |
| | 80% after deductible | 50% after deductible |
| <hr/> | | |
| Home Health Care, Ambulance, Durable Medical Equipment & Hospice | | |
| | 80% after deductible | 50% after deductible |
| <hr/> | | |
| Maternity (Maternity Delivery includes Prenatal & Post-delivery care) | | |
| Hospital Services (Delivery) | 80% after deductible | 50% after deductible |
| Professional Services (Delivery) | 80% after deductible | 50% after deductible |
| <hr/> | | |
| Transplants | | |
| Hospital Services | 80% after deductible | 50% after deductible |
| Professional Services | 80% after deductible | 50% after deductible |
| <hr/> | | |
| Infertility Services <i>(Up to \$5,000)</i> | In-network | Out-of-Network² |
| Primary Care Provider or Specialist | 80% after deductible | 50% after deductible |
| Hospital Services | 80% after deductible | 50% after deductible |
| Inpatient and Outpatient Professional Services | 80% after deductible | 50% after deductible |

| | | |
|------------------------|---------------------|-----------------------------------|
| Vision Care | In-network | Out-of-Network² |
| Comprehensive Eye Exam | 100%, no deductible | Benefits not available |

Mental Health and Substance Abuse Services

Mental Health Services

| | | |
|----------------------|----------------------|----------------------|
| Office | 80% after deductible | 50% after deductible |
| Inpatient/Outpatient | 80% after deductible | 50% after deductible |

Substance Abuse Services

| | | |
|----------------------|----------------------|----------------------|
| Office Visit | 80% after deductible | 50% after deductible |
| Inpatient/Outpatient | 80% after deductible | 50% after deductible |

| | | |
|-------------------------------|----------------------|---|
| PRESCRIPTION DRUGS | 80% after deductible | 80% after deductible |
| MAC C Pricing, Open Formulary | | + charge over in-network allowed amount |

¹. NOTICE: If you selected Employee Coverage, the Employee Coverage deductible and total out of pocket maximum will apply; if you selected Family Coverage the Family Coverage deductible and total out of pocket maximum will apply.

². 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 BCBCNC and its members.

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

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COINSURANCE MAXIMUM

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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 and care management.

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 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 provider. Obtaining certification for Mental health and Substance Abuse services is the member's responsibility.

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 receive Active Blue, our quarterly health magazine and 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
- 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. BCBSNC defines pre-existing conditions as 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.

Health Savings Account

Blue Options HSA is not a Health Savings Account (HSA), but it instead is a health insurance plan intended to be paired with an HSA. The HSA is provided to you directly by a separate HSA Administrator. An HSA is a savings vehicle for medical care expenses. It helps to pay the expenses that insurance does not pay. Individuals and employers can contribute money into an HSA on a tax-deductible

or pre-tax basis for individuals. If used to pay for qualified health care expenses, your HSA account's growth and use is tax-free. In addition, HSAs roll over from year to year and are fully portable if an individual changes jobs. HSAs can only be opened by and contributed to on behalf of individuals who are covered under a qualified High Deductible Health Plan (HDHP). For more information on your HSA eligibility if you have other, additional health coverage, consult your tax advisor.

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

NOTE: Be advised that recent Senate legislation has stated that effective January 1, 2011, participants are required to have a prescription for Over-the-Counter ("OTC") products to be eligible under their FSA plan. Therefore a prescription or letter of medical necessity would be required after January 1, 2011 for OTC items.

Health Savings Account Plan

Monthly Rates for Participants (Wellness)

| | |
|-------------------|----------------|
| Employee | Premium Waived |
| Employee & Child | \$170.65 |
| Employee & Family | \$311.20 |

Monthly Rates for Non-Participants (Wellness)

| | |
|---------------------------------|----------|
| Employee (County pays \$650.00) | \$75.00 |
| Employee & Child | \$245.65 |
| Employee & Family | \$386.20 |

For Customer Service needs and questions, please call
BCBSNC at 1.877.258.3334.

