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## **Blue Cross Blue Shield PPO Health Plan**

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**Effective Date: August 1, 2009**

### **BENEFIT HIGHLIGHTS**

	<u>In-Network</u>	<u>Out-of-Network<sup>1</sup></u>
<b>Physician Office Services (See <i>Outpatient Clinic Services</i>, for “outpatient clinic” or “hospital-based” services)</b>		

#### **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. See “Inpatient and Outpatient Services”.*

Primary Care Provider	\$20 copayment	70% after deductible
Specialist	\$40 copayment	70% after deductible

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#### **Preventive Care**

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

Primary Care Provider	\$20 copayment	Not Available*
Specialist	\$40 copayment	Not Available*

*\*Pap Smears, Mammograms, and PSAs are covered Out-of-network.*

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#### **Therapies**

*Short-term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):*

***Physical/Occupational: 30 visits limit per Benefit Period***

***Speech Therapy: 30 visits limit per Benefit Period***

***Chiropractic Therapy: 30 visits limit per Benefit Period***

Primary Care Provider	\$20 copayment	70% after deductible
Specialist	\$40 copayment	70% after deductible

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#### **URGENT CARE CENTERS AND EMERGENCY ROOM**

Urgent Care Centers	\$40 copayment	\$40 copayment
Emergency Room Visit	\$150 copayment	\$150 copayment

***Emergency Room Visit- (Inpatient Hospital benefits apply if admitted). If held for observation, outpatient benefits apply. See “Inpatient and Outpatient Hospital Services”.***

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<b>AMBULATORY SURGICAL CENTER</b>	90% after deductible	70% after deductible
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#### **INPATIENT AND OUTPATIENT HOSPITAL SERVICES**

Hospital & Hospital Based Services	90% after deductible	70% after deductible
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	<b>In-network</b>	<b>Out-of-Network</b>
Outpatient Clinic Services	90% after deductible	70% after deductible
Professional Services	90% after deductible	70% after deductible
<b>Hospital &amp; Professional</b>		
Outpatient Labs & Mammograms with surgery or other services	90% 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	90% after deductible	70% after deductible
CT scans, MRI's, MRA's and PET scans in any location, including physician's office	90% after deductible	70% after deductible
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<b>Other Services</b>		
<b>Skilled Nursing Facility</b> ( <i>60 days per Benefit Period</i> )		
	90% after deductible	70% after deductible
<b>Home Health Care, Ambulance, Durable Medical Equipment &amp; Hospice</b>		
	90% after deductible	70% after deductible
<b>Maternity</b> ( <i>Maternity Delivery includes Prenatal &amp; Post-delivery care</i> )		
Hospital Services (Delivery)	90% after deductible	70% after deductible
Professional Services (Delivery)	90% after deductible	70% after deductible
<b>Transplants</b>		
Hospital Services	90% after deductible	70% after deductible
Professional Services	90% after deductible	70% after deductible
<b>Infertility Services</b> ( <i>Up to \$5,000 per Lifetime</i> )		
Primary Care Provider	\$20 copayment	70% after deductible
Specialist	\$40 copayment	70% after deductible
Hospital Services	90% after deductible	70% after deductible
Inpatient and Outpatient Professional Services	90% after deductible	70% after deductible
<b>Vision Care</b>		
Comprehensive Eye Exam	\$20 copayment	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-network
<b>Lifetime Benefit Maximum</b>	\$5,000,000	\$5,000,000
<b>Deductibles</b>		
Individual (per Benefit Period)	\$750	\$1,500
Family (per Benefit Period)	\$2,250	\$4,500
<b>Coinsurance Maximum</b>		
Individual (per Benefit Period)	\$2,000	\$4,000
Family (per Benefit Period)	\$6,000	\$12,000

**Certified\***

**Non-Certified<sup>1</sup>**

**MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES**

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

**Mental Health Services**

Office (30 visits per Benefit Period) \$40 copayment 70% after deductible

Inpatient/Outpatient (30 Days per Benefit Period)

90% after deductible 70% after deductible

**(Certain mental health conditions do not have visit limits. For a list of these conditions, refer to your benefit booklet.)**

**Substance Abuse Services**

Office Visit \$40 copayment 70% after deductible

Inpatient/Outpatient 90% after deductible 70% after deductible

Benefit Period Maximum \$8,000

Lifetime Maximum \$16,000

**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.**

**Tier 1 (Generic)** \$0 copay Copayment + charge over in-network allowed amount

**Tier 2 (Preferred Brand)** \$35 copayment Copayment + charge over in-network allowed amount

**Tier 3 (Brand)** \$50 copayment Copayment + charge over in-network allowed amount

<sup>1</sup>**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 charge that BCBSNC determines using a Methodology that is applied to comparable providers for similar services under a similar health benefit plan.

### **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 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. Failure to obtain certification for Mental Health and Substance Abuse services will result in these services being paid at the out-of-network benefit level.

#### **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](http://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.

**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.



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## ***Blue Cross Blue Shield HSA (Health Savings Account)***

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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 2009, your annual contribution is limited to **\$3,000 for individuals** and **\$5,950 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 2009 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.

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.

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.

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, 2009**

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

**BENEFIT HIGHLIGHTS**

	<b><u>In-Network</u></b>	<b><u>Out-of-Network<sup>2</sup></u></b>
<b>Lifetime Maximum, Deductibles, &amp; Total Out of Pocket Maximums</b>		
<i>The following Deductibles and Total Out of Pocket Maximums apply to all services unless otherwise indicated:</i>		
<b>Lifetime Benefit Maximum</b>	\$5,000,000	\$5,000,000
<b>Deductibles</b>		
Employee (per Benefit Period)	\$1,500	\$3,000
Family (per Benefit Period)	\$3,000	\$6,000
<b>Total Out of Pocket Maximum</b>		
Employee (per Benefit Period)	\$3,500	\$7,000
Family (per Benefit Period)	\$5,000	\$10,000

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**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
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**Preventive Care (Preventive Diagnosis Only)**

*Well-ChildCare (Age 2 and under), Immunizations, and the first service each benefit period for 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
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**Other Preventive Care**

Primary Care Provider of Specialist	80% after deductible	50% after deductible
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**Therapies**

*Short-term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):*

*Physical/Occupational: 30 visits limit per Benefit Period*

*Speech Therapy: 30 visits limit per Benefit Period*

Primary Care Provider or Specialist	80% after deductible	50% after deductible
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	<u>In-Network</u>	<u>Out-of-Network<sup>2</sup></u>
<b>Urgent Care Centers and Emergency Room</b>		
Urgent Care Centers	80% after deductible	80% after deductible
Emergency Room Visit	80% after deductible	80% after deductible
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<b>AMBULATORY SURGICAL CENTER</b>		
	80% after deductible	50% after deductible
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<b>Outpatient Hospital Services</b> <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
<b>Inpatient Hospital Services</b> <i>(includes physician services, hospital and hospital-based services, and maternity delivery, prenatal and post-delivery care.)</i>		
	80% after deductible	50% after deductible
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<b>Other Services</b>		
<b>Skilled Nursing Facility (60 days per Benefit Period)</b>		
	80% after deductible	50% after deductible
<b>Home Health Care, Ambulance, Durable Medical Equipment &amp; Hospice</b>		
	80% after deductible	50% after deductible
<b>Maternity (Maternity Delivery includes Prenatal &amp; Post-delivery care)</b>		
Hospital Services (Delivery)	80% after deductible	50% after deductible
Professional Services (Delivery)	80% after deductible	50% after deductible
<b>Transplants</b>		
Hospital Services	80% after deductible	50% after deductible
Professional Services	80% after deductible	50% after deductible
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<b>Infertility Services</b> <i>(Up to \$5,000 per Lifetime)</i>	<b>In-network</b>	<b>Out-of-Network<sup>2</sup></b>
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
Infertility Drugs	80% after deductible	80% after deductible

<b>Vision Care</b>	<b>In-network</b>	<b>Out-of-Network<sup>2</sup></b>
Comprehensive Eye Exam	80% after deductible	50% after deductible

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	<b><u>Certified*</u></b>	<b><u>Non-Certified<sup>2</sup></u></b>
<b>Mental Health and Substance Abuse Services</b>		

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

**Mental Health Services**

Office (30 visits per Benefit Period)	80% after deductible	50% after deductible
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Inpatient/Outpatient (30 Days per Benefit Period)	80% after deductible	50% after deductible
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*(Certain mental health conditions do not have visit limits. For a list of these conditions, refer to your benefit booklet.)*

**Substance Abuse Services**

Office Visit	80% after deductible	50% after deductible
Inpatient/Outpatient	80% after deductible	50% after deductible
Benefit Period Maximum		\$8,000
Lifetime Maximum		\$16,000

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<b>PRESCRIPTION DRUGS</b>	80% after deductible	80% after deductible
MAC C Pricing, Open Formulary		

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<sup>1</sup>: 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.

<sup>2</sup>: NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage 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**

The charge that BCBSNC determines using a Methodology that is applied to comparable providers for similar services under a similar health benefit plan.

### **TOTAL OUT OF POCKET MAXIMUM**

The dollar amount of total out of pocket expenses a member must pay prior to BCBSNC paying 100% for certain services. It includes the deductible and coinsurance.

### **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.

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#### **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](http://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
- 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 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. The HSA is provided to you directly by a separate HSA Administrator. Detailed information regarding your HSA is provided by that Administrator.

**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. For more information on your HSA eligibility if you have other additional health coverage, consult your tax advisor.

**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.

