

# Health Plan - PPO

## BCBSNC Blue Options<sup>SM</sup>

### PHYSICIAN OFFICE SERVICES

#### In-Network

#### Out-of-Network<sup>1</sup>

#### 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	\$20 copayment	70% after deductible
Specialist	\$40 copayment	70% after deductible

#### Preventive Care

*Routine Examinations, Well-Child Care, 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.*

#### 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 Provider	\$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	\$150 copayment	\$150 copayment

**AMBULATORY SURGICAL CENTER** 90% after deductible 70% after deductible

### INPATIENT AND OUTPATIENT HOSPITAL SERVICES

Hospital and Hospital Based Services	90% after deductible	70% after deductible
Outpatient Clinic Services	90% after deductible	70% after deductible
Physicians Services	90% after deductible	70% after deductible

#### Hospital and Professional

Outpatient Labs and Mammograms with surgery or other services.

90% 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, and colonoscopies 90% after deductible 70% after deductible

CT scans, MRI's, MRA's and PET scans in any location, including physicians office

90% after deductible 70% after deductible

### OTHER SERVICES

#### Skilled Nursing Facility

*(60 days per benefit period)*

90% after deductible 70% after deductible

	<b><u>In-Network</u></b>	<b><u>Out-of-Network</u></b> <sup>1</sup>
<b>Home Health Care, Ambulance, Durable Medical Equipment, and Hospice</b>		
	90% after deductible	70% after deductible
<b>Maternity</b>		
<i>(Maternity Delivery includes Prenatal and 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 and Sexual Dysfunction 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

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**LIFETIME MAXIMUM, DEDUCTIBLES & COINSURANCE MAXIMUMS**

*(The following Deductibles and Coinsurance Maximums apply to the services in the previous sections:*

<b>Lifetime Benefit Maximum</b>	\$5,000,000	\$5,000,000
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**Deductibles**

Employee Coverage <i>(per Benefit Period)</i>	\$500	\$1,000
Family Coverage <i>(per Benefit Period)</i>	\$1,500	\$3,000

**Coinsurance Maximum**

Employee Coverage <i>(per Benefit Period)</i>	\$2,000	\$4,000
Family Coverage <i>(per Benefit Period)</i>	\$6,000	\$12,000

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**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 <i>(Generic)</i>	\$10 copayment	Copayment + charge over allowed amount
Tier 2 <i>(Preferred Brand)</i>	\$35 copayment	Copayment + charge over allowed amount
Tier 3 <i>(Brand)</i>	\$50 copayment	Copayment + charge over allowed amount

## MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

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

<b>Mental Health Services</b>	<b><u>Certified*</u></b>	<b><u>Non-Certified<sup>1</sup></u></b>
Office (20 visits per Benefit Period)	\$40 copayment	70% coinsurance
Inpatient (30 Days per Benefit Period)	90% coinsurance	70% coinsurance
<b>Substance Abuse Services</b>		
Office Visit	\$40 copayment	70% coinsurance
Inpatient/Outpatient	90% coinsurance	70% coinsurance
Benefit Period Maximum		\$8,000
Lifetime Maximum		\$16,000

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<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.

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## ADDITIONAL INFORMATION ABOUT THE BLUE OPTIONS PPO PLANS 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 which 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. 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 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 (with the exception of insulin)

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.

These benefit highlights are summaries 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.

## **PPO MONTHLY RATES**

**(Participating in the Wellness Program)**

<b>Employee Only</b>	<b>\$0</b>
<b>Employee + Child</b>	<b>\$85.00</b>
<b>Employee + Family</b>	<b>\$245.00</b>

**(NOT Participating in the Wellness Program)**

<b>Employee Only</b>	<b>\$30.00</b>
<b>Employee + Child</b>	<b>\$115.00</b>
<b>Employee + Family</b>	<b>\$275.00</b>

**FOR CLAIMS OR CUSTOMER SERVICES QUESTIONS PLEASE CALL  
BLUECROSS BLUESHIELD OF NORTH CAROLINA AT:**

**(877) 258-3334**

**[www.bcbsnc.com](http://www.bcbsnc.com)**

