# Blue Options[SM] Benefit Highlights (PPO)

| | In-network | Out-of-network[1] |
|---|---|---|
| **Campus Health Services** *(Medical Services)* | 100%, no deductible | Not applicable |
| **Physician Office Visit** | | |
| *Includes Office Surgery, Consultation, X-rays, Lab and benefit period maximum of 4 office visits for the assessment of obesity* in *and out of network.* | | |
| Primary Care Provider | 80% after deductible | 70% after deductible |
| Specialist | 80% after deductible | 70% after deductible |
| **Preventive Care** | | |
| *Routine Examinations, Well-Child Care, 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* | | |
| Primary Care | 80% after deductible | 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 *(Copay Waived and Inpatient benefits apply if admitted. If held for Observation, Outpatient benefits apply.)* | $150,then 80% after ded | $150,then 80% after ded |
| **Ambulatory Surgical Center** | 80% after deductible | 70% after deductible |
| **Inpatient and Outpatient Hospital Services** | | |
| Hospital, Hospital Based Services and Outpatient Clinic Services | 80% after deductible | 70% after deductible |
| Professional Services | 80% after deductible | 70% after deductible |
| Hospital and Professional | | |
| Outpatient Labs and Mammograms | 80% after deductible | 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 |
| **Other Services** | | |
| **Skilled Nursing Facility** *(60 days per Benefit Period)* | 80% after deductible | 70% after deductible |
| **Home Health Care, Durable Medical Equipment and Hospice** | 80% after deductible | 70% after deductible |
| **Ambulance** | 80% after deductible | 80% after deductible |
| **Maternity** *(Maternity Delivery includes Prenatal and Post-delivery care)* | | |
| 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** *(Up to $5,000 per Lifetime)* | | |
| Primary Care Provider | 80% after deductible | 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 | Not applicable |

# Blue Options[SM] Benefit Highlights (PPO)

| Lifetime Maximum, Deductibles & Coinsurance Maximums | In-network | Out-of-network[1] |
|---|---|---|
| *The following Deductibles and Coinsurance Maximums apply to the services on the previous page and Mental Health and Substance Abuse services below:* | | |
| **Lifetime Benefit Maximum** | Unlimited | |
| **Deductibles** | | |
| Individual *(per Benefit Period)* | $300 | $400 |
| Family *(per Benefit Period)* | $900 | $1,200 |
| **Out of Pocket Maximum** | | |
| Individual *(per Benefit Period)* | $2,100 | $4,200 |
| Family *(per Benefit Period)* | $6,300 | $12,600 |
| **Mental Health and Substance Abuse Services** | | |
| *Precertification required for Inpatient and certain Outpatient services. Call Magellan Behavioral Health at 1-800-359-2422.* | | |
| **Mental Health Services** | | |
| Office Visit | 80% after deductible | 70% after deductible |
| Inpatient/Outpatient | 80% after deductible | 70% after deductible |
| **Substance Abuse Services** | | |
| Office Visit | 80% after deductible | 70% after deductible |
| Inpatient/Outpatient | 80% after deductible | 70% after deductible |
| **Prescription Drugs** | | |
| **Campus Health Services** | | |
| Generic or Brand *(30 day supply)* | $10 copayment | Not applicable |
| **Other Pharmacy** | | |
| *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 per Lifetime. MAC C Pricing.* | | |
| Tier 1 *(Generic)* | $20 copayment | 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 |
| Tier 4 *(Specialty Brand)* | 25% coinsurance | Coinsurance + charge over In-network allowed amount |
| There is $50 per Drug Minimum and $100 per Drug Maximum for each 30-day supply of Tier 4 Specialty Brand drugs. | | |
| **Lens and Frame Coverage** *(BCBSNC will reimburse you up to the Benefit Period Maximum for glasses, hard, soft or disposable contact lenses.)* | | |
| Prescribed Eyeglass Lens and Frame Reimbursement *(per Benefit Period )* | $150 | |

[1] 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.