

BCBSNC CHOICE PLAN

<p>This Plan pays 100% for in-network adult or child wellness charges. Copays apply to prescription drugs and office visits for physician, specialist, mental health/substance abuse, and in-network urgent care. For most other charges, after satisfying the annual deductible, the Plan pays a percentage of the covered charge (coinsurance). Each time medical care is needed, patient decides which physician to use. Higher level of benefits applies when in-network provider is used.</p>		
<p>Plan Provisions <i>Note: Copays, coinsurance, and deductible shown below are amounts paid by employee.</i></p>		
Annual deductible ¹	\$750 individual / \$1,500 family in- or out-of-network (coinsurance applies thereafter)	
Out-of-pocket limit ²	\$3,000 Individual / \$6,000 family in- or out-of-network	
Maximum lifetime Plan benefit ³	\$2,000,000 per person	
The annual deductible does not apply to the following:		
Preventive care (primary diagnosis must be wellness) Mammograms Routine adult physical/wellness exams (including related tests and GYN exams) Well baby/child visits (including immunizations)	Covered at 100% of allowed amount	
	Covered at 100% in-network	40% out-of-network
Mental health/substance abuse services ⁴	See EAP and Mental Health and Substance Abuse Benefits Summary	
Prescription drugs at participating pharmacies ⁵ Generic Preferred Brand Name Non-Preferred Brand Name Elective ⁶	Catalyst Rx Retail (up to 30 days)	Walgreen's Mail Order (up to 90 days)
	\$10	\$25
	\$20	\$50
	\$35	\$85
Once the deductible is met, the following charges are subject to coinsurance. Copays, not coinsurance and deductible, apply to office and urgent care visits if member is not eligible for Medicare or Medicare is secondary.		
	In-Network	Out-of-Network⁷
Physician office services (includes exams, diagnosis, lab services, non-surgical injections) Physician (includes family practice, OB/GYN, and internal medicine – unless practicing in a specialty area) Specialist	\$25/20% ^{8,9}	40% ⁸
	\$35/20% ^{8,9}	40% ⁸
Office/surgical procedures (including MRI, PET, CT scans and nuclear medicine)	20% ⁸	40% ⁸
Urgent care center ¹⁰	\$35/20% ⁹	\$35/20% ⁹
Emergency room ¹¹	20%	20%
Hospital inpatient services ¹² Inpatient services (room, lab, x-ray) Providers (physician, surgeon) Radiologist, anesthesiologist, pathologist, ER physician	20% ⁸	40% ^{8, 13}
	20% ⁸	40% ⁸
	20% ^{8, 14}	40% ^{8, 14}
Outpatient services Outpatient facility fee Outpatient facility services (lab, x-ray) Providers (physician, surgeon) Radiologist, anesthesiologist, pathologist, ER physician	20% ⁸	40% ⁸
	20% ⁸	40% ⁸
	20% ⁸	40% ⁸
	20% ^{8, 14}	40% ^{8, 14}
Occupational/physical/speech therapy; spinal manipulation ¹⁵	\$35/20% ^{8,9}	40% ⁸

Durable medical equipment	20% ⁸	40% ⁸
---------------------------	------------------	------------------

1. Deductible is the amount you must pay each calendar year before the Plan pays a benefit. Services that require a copay, preventive care, mental health/substance abuse or prescription drug charges do not apply towards the deductible.