

BCBSNC STANDARD PLAN

<p>This Plan pays 100% for in-network adult or child wellness charges. Copays only apply to prescription drugs and mental health/substance abuse office visits. For all 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	\$1,500 individual / \$3,000 family in- or out-of-network (coinsurance applies thereafter)	
Out-of-pocket limit ²	\$4,000 individual / \$8,000 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)	Covered at 100% of allowed amount	
Mammograms	Covered at 100% of allowed amount	
Routine adult physical/wellness exams (including related tests and GYN exams)	Covered at 100% in-network	40% out-of-network
Well baby/child visits (including immunizations)	Covered at 100% of allowed amount	
Mental health/substance abuse services ⁴	See EAP and Mental Health and Substance Abuse Benefits Summary	
Prescription drugs at participating pharmacies ⁵	Catalyst Rx Retail (up to 30 days)	Walgreen's Mail Order (up to 90 days)
Generic	\$10	\$25
Preferred Brand Name	\$20	\$50
Non-Preferred Brand Name	\$35	\$85
Elective ⁶		
Once the deductible is met, the following charges are subject to coinsurance:		
	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)	20% ⁸	40% ⁸
Specialist	20% ⁸	40% ⁸
Office/surgical procedures (including MRI, PET, CT scans and nuclear medicine)	20% ⁸	40% ⁸
Urgent care center ⁹	20%	20%
Emergency room ¹⁰	20%	20%
Hospital inpatient services ¹¹		
Inpatient services (room, lab, x-ray)	20% ⁸	40% ^{8, 12}
Providers (physician, surgeon)	20% ⁸	40% ⁸
Radiologist, anesthesiologist, pathologist, ER physician	20% ^{8, 13}	40% ^{8, 13}
Outpatient services		
Outpatient facility fee	20% ⁸	40% ⁸
Outpatient facility services (lab, x-ray)	20% ⁸	40% ⁸
Providers (physician, surgeon)	20% ⁸	40% ⁸
Radiologist, anesthesiologist, pathologist, ER physician	20% ^{8, 13}	40% ^{8, 13}
Occupational/physical/speech therapy; spinal manipulation ¹⁴	20% ⁸	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. Preventive care, mental

- health/substance abuse services or prescription drug charges do not apply towards the deductible.
2. Does not include prescription drug copays, mental health/substance abuse expenses, charges in excess of allowed amount, services not pre-certified, or non-covered services; Plan pays 100% of allowed amount once out-of-pocket limit is met.
 3. Includes benefits paid for medical, mental health, substance abuse services and prescription drugs.
 4. Services are provided through ValueOptions and must be pre-certified; annual deductible does not apply.
 5. Prescription drugs are provided through Catalyst Rx; annual deductible does not apply.
 6. Elective copay equals \$10 plus difference in cost between brand name and generic drug. Applies if patient elects brand name when the prescription is written to allow generic substitution. Does not apply for mail order prescriptions.
 7. Out-of-network charges are subject to allowed amount.
 8. Prior Plan Approval (PPA) (precertification before services occur) required for certain health care services from providers outside of North Carolina or any out-of-network providers. If not precertified, benefits may be denied or paid at 50% of allowed amount.
 9. Treatment must meet urgent care criteria.
 10. \$50 copay required in addition to deductible and coinsurance; waived if admitted or if Medicare is primary; must meet emergency care criteria.
 11. If not pre-certified in- or out-of-network, benefits reduced to 50% of allowed amount.
 12. \$400 out-of-network hospital copay required in addition to deductible and coinsurance.
 13. 20% coinsurance if performed at an in-network facility or on the same day as an in-network provider visit; 40% coinsurance if performed at an out-of-network facility
 14. Limited to 60 visits/year for all therapies combined.