



**BlueCross BlueShield  
of North Carolina**

Your plan for better health.<sup>SM</sup> | [bcbsnc.com](http://bcbsnc.com)

# BlueOptions<sup>SM</sup>

## Benefit Highlights

**DUPLIN COUNTY**

**JULY 1, 2011**



## Blue Options<sup>SM</sup> Benefit Highlights (PPO)

	In-network	Out-of-network <sup>1</sup>
<b>Physician Office Services</b>		
<i>(See "Outpatient Clinic Services" for "outpatient clinic" or "hospital-based" services.)</i>		
<b>Office Visit</b>		
<i>Includes Office Surgery, Consultation, X-ray and Lab, and benefit period maximum of 4 office visits for the assessment of obesity in and out of network. See "Inpatient and Outpatient Services".</i>		
Primary Care Provider	\$30 copayment	60% after deductible
Specialist	\$60 copayment	60% after deductible
<b>Preventive Care</b>		
<i>Routine Examinations, Well-Child Care, Immunizations, Gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, newborn hearing screening and prostate specific antigen tests (PSAs).</i>		
Primary Care Provider	100%, no deductible	Not Available*
Specialist	100%, no deductible	Not Available*
Outpatient Clinic	100%, no deductible	Not Available*
<i>*Gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, newborn hearing screening and prostate specific antigen tests (PSAs) are covered Out-of-network.</i>		
<b>Therapies</b>		
<i>Short-term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):</i>		
<i>Physical/Occupational: 30 per Benefit Period; Speech Therapy: 30 per Benefit Period</i>		
Primary Care	\$30 copayment	60% after deductible
Specialist	\$60 copayment	60% after deductible
<b>Urgent Care Centers and Emergency Room</b>		
Urgent Care Centers	\$60 copayment	\$60 copayment
Emergency Room Visit <i>(Inpatient Hospital benefits apply if admitted. If held for observation, outpatient benefits apply. See "Inpatient and Outpatient Hospital Services".)</i>	\$350 copayment	\$350 copayment
<b>Ambulatory Surgical Center</b>	70% after deductible	60% after deductible
<b>Inpatient and Outpatient Hospital Services</b>		
Hospital and Hospital Based Services	70% after deductible	60% after deductible
Outpatient Clinic Services (other than preventive services above)	70% after deductible	60% after deductible
Professional Services	70% after deductible	60% after deductible
Hospital and Professional		
Outpatient Labs and Mammograms with surgery or other services	70% after deductible	60% after deductible
Outpatient Labs and Mammograms without surgery or other services	100%, no deductible	60% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests, such as EEG's and EKG's	100%, no deductible	60% after deductible
CT scans, MRI's, MRA's and PET scans in any location, including physician's office	100%, no deductible	60% after deductible
<b>Other Services</b>		
<b>Skilled Nursing Facility</b> <i>60 days per Benefit Period</i>	70% after deductible	60% after deductible
<b>Home Health Care, Ambulance, Durable Medical Equipment and Hospice</b>	70% after deductible	60% after deductible
<b>Maternity</b>		
<i>Maternity Delivery includes Prenatal and Post-delivery care</i>		
Hospital Services (Delivery)	70% after deductible	60% after deductible
Professional Services (Delivery)	70% after deductible	60% after deductible
<b>Transplants</b>		
Hospital Services	70% after deductible	60% after deductible
Professional Services	70% after deductible	60% after deductible
<b>Infertility Services</b>		
<i>Up to \$5,000 Lifetime Maximum</i>		
Primary Care Provider	\$30 copayment	60% after deductible
Specialist	\$60 copayment	60% after deductible
Hospital Services	70% after deductible	60% after deductible
Inpatient and Outpatient Professional Services	70% after deductible	60% after deductible
<b>Vision Care</b>		
Routine Eye Exam	100%, no deductible	Benefits not available

**Blue Options<sup>SM</sup> Benefit Highlights (PPO)**

<b>Lifetime Maximum, Deductibles &amp; Coinsurance Maximums</b>	<b>In-network</b>	<b>Out-of-network<sup>1</sup></b>
<i>The following Deductibles and Coinsurance Maximums apply to the services on the previous page [and Mental Health and Substance Abuse services below]:</i>		
<b>Lifetime Benefit Maximum</b>	Unlimited	Unlimited
<b>Deductibles</b>		
Individual (per Benefit Period)	\$2,000	\$4,000
Family (per Benefit Period)	\$4,000	\$8,000
<b>Coinsurance Maximum</b>		
Individual (per Benefit Period)	\$2,000	\$4,000
Family (per Benefit Period)	\$6,000	\$12,000

**Mental Health and Substance Abuse Services**

*Inpatient/Outpatient Certification - Magellan Behavioral Health at 1-800-359-2422*

**Mental Health Services**

Office	\$60 copayment	60% after deductible
Inpatient/Outpatient	70% after deductible	60% after deductible

**Substance Abuse Services**

Office Visit	\$60 copayment	60% after deductible
Inpatient/Outpatient	70% after deductible	60% after deductible]

**Prescription Drugs**

*Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments. 2x Copay for Mailorder.*

*Infertility Drugs up to \$5,000 LTM. Mac B Pricing, Brand Penalty.*

Tier 1 (Generic)	\$4 copayment	Copayment + charge over In-network allowed amount
Tier 2 (Preferred Brand)	\$45 copayment	Copayment + charge over In-network allowed amount
Tier 3 (Brand)	\$60 copayment	Copayment + charge over In-network allowed amount
Tier 4 (Specialty Brand)	75% coinsurance	Coinsurance + charge over In-network allowed amount

There is a \$50 per Drug Minimum and \$100 per Drug Maximum for each 30-day supply of Tier 4 Specialty Brand drugs.

<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.

