Blue Options℠ Benefit Highlights (PPO)- HIGH PLAN OPTION

	In-network	Out-of-network[1]
Physician Office Services *(See "Outpatient Clinic Services" for "outpatient clinic" or "hospital-based" services.)*		
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. See "Inpatient and Outpatient Services".*		
Primary Care Provider	$20 copayment	80% after deductible
Specialist	$30 copayment	80% after deductible
Preventative Care *Routine Examinations, Well-Child Care, Immunizations, Pap Smears, Mammograms, Prostate Specific Antigen Tests (PSAs)*		
Primary Care Provider	$20 copayment	Not Available*
Specialist	$30 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	$20 copayment	80% after deductible
Specialist	$30 copayment	80% after deductible
Urgent Care Centers and Emergency Room		
Urgent Care Centers	$30 copayment	$30 copayment
Emergency Room Visit *(Inpatient Hospital benefits apply if admitted. If held for observation, outpatient benefits apply. See "Inpatient and Outpatient Hospital Services".)*	$150 copayment	$150 copayment
Ambulatory Surgical Center	100% after deductible	80% after deductible
Inpatient and Outpatient Hospital Services		
Hospital and Hospital Based Services	100% after deductible	80% after deductible
Outpatient Clinic Services	100% after deductible	80% after deductible
Professional Services	100% after deductible	80% after deductible
Hospital and Professional		
Outpatient Labs and Mammograms with surgery or other services.	100% after deductible	80% after deductible
Outpatient Labs and Mammograms without surgery or other services.	100%	80% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEG's and EKG's	100% after deductible	80% after deductible
CT scans, MRI 's, MRA's and PET scans in any location, including physician's office	100% after deductible	80% after deductible
Other Services		
Skilled Nursing Facility *(60 days per Benefit Period)*	100% after deductible	80% after deductible
Home Health Care, Ambulance, Durable Medical Equipment and Hospice	100% after deductible	80% after deductible
Maternity *Maternity Delivery includes Prenatal and Post-delivery care*		
Hospital Services *(Delivery)*	100% after deductible	80% after deductible
Professional Services *(Delivery)*	100% after deductible	80% after deductible
Transplants		
Hospital Services	100% after deductible	80% after deductible
Professional Services	100% after deductible	80% after deductible
Infertility Services *Up to $5,000 per Lifetime*		
Primary Care Provider	$20 copayment	80% after deductible
Specialist	$30 copayment	80% after deductible
Hospital Services	100% after deductible	80% after deductible
Inpatient and Outpatient Professional Services	100% after deductible	80% after deductible
Vision Care		
Comprehensive Eye Exam	$20 copayment	Benefits not available

(SEE BACK FOR MORE BENEFIT INFORMATION)

Blue Options℠ Benefit Highlights (PPO)

Lifetime Maximum, Deductibles & Coinsurance Maximums	In-network	Out-of-network [1]
The following Deductibles and Coinsurance Maximums only apply to the services on the previous page and Mental Health and Substance Abuse services below:		
Lifetime Benefit Maximum	Unlimited	Unlimited
Deductibles		
Individual *(per Benefit Period)*	$500	$1,000
Family *(per Benefit Period)*	$1,000	$2,000
Coinsurance Maximum		
Individual *(per Benefit Period)*	$0	$1,250
Family *(per Benefit Period)*	$0	$2,500

Mental Health and Substance Abuse Services	Certified*	Not-Certified[1]
**Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422.*		
Mental Health Services		
Office	$30 copayment	80% after deductible
Inpatient/Outpatient	100% after deductible	80% after deductible
Substance Abuse Services		
Office Visit	$30 copayment	80% after deductible
Inpatient/Outpatient	100% after deductible	80% after deductible

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	In-network	Out-of-network
Tier 1 *(Generic)*	$10 copayment	Copayment + charge over In-network allowed amount
Tier 2 *(Preferred Brand)*	$25 copayment	Copayment + charge over In-network allowed amount
Tier 3 *(Brand)*	$40 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 for each 30-day supply of Tier 4 Specialty Brand drugs.
There is a $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 Benefit Period Maximum	$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 BCBNC and its members.