

## Blue Options<sup>SM</sup> Benefit Highlights (PPO) \_ LOW PLAN OPTION

	In-network	Out-of-network <sup>1</sup>
<b>Physician Office Services</b> (See "Outpatient Clinic Services" for "outpatient clinic" or "hospital-based" services.)		
<b>Office Visit</b> <i>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".</i>		
Primary Care Provider	\$20 copayment	70% after deductible
Specialist	\$30 copayment	70% after deductible
<b>Preventative Care</b> <i>Routine Examinations, Well-Child Care, Immunizations, Pap Smears, Mammograms, Prostate Specific Antigen Tests (PSAs)</i>		
Primary Care Provider	\$20 copayment	Not Available*
Specialist	\$30 copayment	Not Available*
*Pap Smears, Mammograms, and PSAs are covered Out-of-network.		
<b>Therapies</b> <i>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</i>		
Primary Care	\$20 copayment	70% after deductible
Specialist	\$30 copayment	70% after deductible
<b>Urgent Care Centers and Emergency Room</b>		
Urgent Care Centers	\$30 copayment	\$30 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>	\$150 copayment	\$150 copayment
<b>Ambulatory Surgical Center</b>		
	80% after deductible	70% after deductible
<b>Inpatient and Outpatient Hospital Services</b>		
Hospital and Hospital Based Services	80% after deductible	70% after deductible
Outpatient Clinic Services	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible
Hospital and Professional		
Outpatient Labs and Mammograms with surgery or other services.	80% after deductible	70% after deductible
Outpatient Labs and Mammograms without surgery or other services.	100%	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
<b>Other Services</b>		
Skilled Nursing Facility <i>(60 days per Benefit Period)</i>	80% after deductible	70% after deductible
Home Health Care, Ambulance, Durable Medical Equipment and Hospice	80% after deductible	70% after deductible
<b>Maternity</b> <i>Maternity Delivery includes Prenatal and Post-delivery care</i>		
Hospital Services <i>(Delivery)</i>	80% after deductible	70% after deductible
Professional Services <i>(Delivery)</i>	80% after deductible	70% after deductible
<b>Transplants</b>		
Hospital Services	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible
<b>Infertility Services</b> <i>Up to \$5,000 per Lifetime</i>		
Primary Care Provider	\$20 copayment	70% after deductible
Specialist	\$30 copayment	70% after deductible
Hospital Services	80% after deductible	70% after deductible
Inpatient and Outpatient Professional Services	80% after deductible	70% after deductible
<b>Vision Care</b>		
Comprehensive Eye Exam	\$20 copayment	Benefits not available

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

Lifetime Maximum, Deductibles & Coinsurance Maximums	In-network	Out-of-network <sup>1</sup>
<i>The following Deductibles and Coinsurance Maximums only apply to the services on the previous page and Mental Health and Substance Abuse services below:</i>		
Lifetime Benefit Maximum	Unlimited	Unlimited
<b>Deductibles</b>		
Individual (per Benefit Period)	\$500	\$1,000
Family (per Benefit Period)	\$1,000	\$2,000
<b>Coinsurance Maximum</b>		
Individual (per Benefit Period)	\$3,000	\$6,000
Family (per Benefit Period)	\$6,000	\$12,000

Mental Health and Substance Abuse Services	Certified*	Not-Certified <sup>1</sup>
<i>*Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422.</i>		
<b>Mental Health Services</b>		
Office	\$30 copayment	70% after deductible
Inpatient/Outpatient	80% after deductible	70% after deductible
<b>Substance Abuse Services</b>		
Office Visit	\$30 copayment	70% after deductible
Inpatient/Outpatient	80% after deductible	70% 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 1 (Generic)	\$10 copayment	Copayment + charge over In-network allowed amount
Tier 2 (Preferred Brand)	\$30 copayment	Copayment + charge over In-network allowed amount
Tier 3 (Brand)	\$45 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

<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 BCBNC and its members.

METHODIST UNIVERSITY

Prospect 130738, Quote 2963287 Effective Date: 01/2010 Quote Date: 11/11/2009