



Blue Options SM Proposal For
CITY OF KINSTON

Effective 07/2014

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Prospect Number 126190

Quote Number 4608285

The benefit highlight is a summary of Blue Options benefits. This is meant only to be a summary. You will also be receiving a Summary of Benefits and Coverage document (referred to as an SBC) required under Health Care Reform. Both documents are provided as a convenience to compare available health plan coverage options. Final interpretation of the Blue Options health plan and a complete listing of benefits and what is not covered are found in and governed by the group contract and benefit booklet. You may preview the benefit booklet by requesting a copy of the Blue Options benefit booklet from BCBSNC Customer Services.

Blue Options SM Benefit Highlights (PPO)

The coinsurance amounts that appear on this benefit highlight represent Plan responsibility. The coinsurance amounts that display in the benefit booklet represent member responsibility.

Physician Office Services In-network Out-of-Network¹

(See "Hospital Based Clinics" for "outpatient clinic" or "hospital-based" services.)

Office Visit

Includes Office Surgery, Consultation, X-rays and Labs, and a benefit period maximum of 4 office visits for the evaluation and treatment of obesity In and out-of-network. See "Inpatient and Outpatient Services".

Primary Care Provider	\$35 copayment	70% after deductible
Specialist	\$70 copayment	70% after deductible

Preventive Care (Primary Preventative Diagnosis Only)

For the most updated list of general preventive/screenings. Immunizations, well-baby/well-child care and women's preventive care services mandated under Federal law, see our website at bcbsnc.com/preventive.

Routine eye exams are covered only In-Network as non-mandated Preventive Care.

Nutritional counseling is covered and available In-Network and Out-of-Network.

Primary Care Provider	100% no deductible	Not Available ²
Specialist	100% no deductible	Not Available ²

² Colorectal screening, bone mass measurement, newborn hearing screening, prostate specific antigen tests (PSAs),

gynecological exams, cervical cancer screening, ovarian cancer screening and mammograms are state mandated and also covered Out-of-Network.

Therapies

Rehabilitative and Habilitative 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 Provider	\$35 copayment	70% after deductible
Specialist	\$70 copayment	70% after deductible

Urgent Care Centers and Emergency Room

Urgent Care Centers	\$70 copayment	\$70 copayment
Emergency Room Visit	\$150 copayment	\$150 copayment

(If admitted from the ER, the copayment does not apply; instead, Inpatient Hospital benefits apply. If held for observation, outpatient benefits apply. See "Inpatient and Outpatient Hospital Services".)

Ambulatory Surgical Center 70% after deductible 50% after deductible

Inpatient and Outpatient Hospital Services

Hospital and Hospital Based Services	70% after deductible	50% after deductible
Hospital Based Clinics (other than preventive services above)	70% after deductible	50% after deductible
Professional Services	70% after deductible	50% after deductible
Outpatient Diagnostic Services		
Outpatient lab tests and mammography, when performed alone (Physician and Hospital-based services)	100% no deductible	70% after deductible
Outpatient lab tests and mammography, when performed with another service		
Physician Services	100% no deductible	70% after deductible
Hospital and Hospital-based Services	70% after deductible	50% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic tests such as EEG's and EKG's	70% after deductible	50% after deductible
CT scans, MRI's, MRA's, and PET scans in any location, including physicians office	70% after deductible	50% after deductible

Other Services

Skilled Nursing Facility (60 days per Benefit Period)	70% after deductible	50% after deductible
Home Health Care Durable Medical Equipment and Hospice	70% after deductible	50% after deductible
Ambulance	70% after deductible	70% after deductible

Maternity

Maternity Delivery includes Prenatal and Post-delivery care

Hospital Services (delivery)	70% after deductible	50% after deductible
Professional Services (delivery)	70% after deductible	50% after deductible

Transplants

Hospital Services	70% after deductible	50% after deductible
Professional Services	70% after deductible	50% after deductible

Infertility Services

Combined In-Network and Out-of-Network Lifetime Maximum of 3 ovulation induction cycles, with or without insemination, per Member for infertility services, provided in all places of services.

Primary Care Provider	\$35 copayment	70% after deductible
Specialist	\$70 copayment	70% after deductible
Hospital Services	70% after deductible	50% after deductible
Inpatient and Outpatient Professional Services	70% after deductible	50% after deductible

Blue Options SM Benefit Highlights (PPO)

Lifetime Maximum, Deductibles & Out-of-Pocket Limits	In-Network	Out-of-Network ¹
<i>The following Deductibles and Out-of-Pocket limits apply to all services unless otherwise indicated and Mental Health and Substance Abuse services below:</i>		
Lifetime Benefit Maximum	Unlimited	Unlimited
Deductibles		
Individual (<i>per Benefit Period</i>)	\$1,750	\$3,500
Family (<i>per Benefit Period</i>)	\$3,500	\$7,000
Out-of-Pocket Limits		
Individual (<i>per Benefit Period</i>)	\$3,750	\$7,500
Family (<i>per Benefit Period</i>)	\$7,500	\$15,000

Mental Health and Substance Abuse Services

Mental Health Services		
Office Visit	\$70 copayment	70% after deductible
Inpatient/Outpatient	70% after deductible	50% after deductible
Substance Abuse Services		
Office Visit	\$70 copayment	70% after deductible
Inpatient/Outpatient	70% after deductible	50% after deductible

Prescription Drugs

*Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments.
MAC B Pricing, Brand Penalty*

Tier 1 (Generic Drugs)	\$4 copayment	\$4 copayment
Tier 2 (Preferred Brand Drugs)	\$30 copayment	\$30 copayment
Tier 3 (Non-Preferred Brand and Preferred Specialty Drugs)	\$45 copayment	\$45 copayment
Tier 4 (Non-Preferred Specialty Drugs)	75%	75%

For each 30-day supply for a Tier 4 Specialty Drug, you will pay a minimum of \$50

In coinsurance, but not more than \$100. Any Out-of-Network charges over the allowed amount are not included in this maximum. You are responsible for charges over the allowed amount received from an out-of-network pharmacy. Limits apply to infertility drugs, refer to your benefit booklet.

Preventive OTC Medications and Contraceptive Drugs and Devices as listed at bcbsnc.com/preventive	100% no deductible	100% no deductible
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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 BCBSNC and its members.

ADDITIONAL INFORMATION ABOUT BLUE OPTIONS FROM BCBSNC

Benefit Period

The period of time, usually 12 months as stated in the group contract, during which charges for covered services provided to a member must be incurred in order to be eligible for payment by BCBSNC. A charge shall be considered incurred on the date the service or supply was provided to a member.

Allowed Amount

The maximum amount that BCBSNC determines is to be paid for covered services provided to a member.

Out-of-Pocket Limit

The dollar amount you pay for covered services in a benefit period before BCBSNC pays 100% of covered services. It includes deductible, coinsurance and copayments. It does not include charges over the allowed amount, premiums, and charges for non-covered services.

Day and Visit Maximums

All day and visit maximums are on a combined In-and Out-of-Network bases.

Utilization Management

To make sure you have access to high quality, cost-effective health care, we manage utilization through a variety of programs including certification, transplant management, concurrent and retrospective review.

If you have a concern regarding the final determination of your care, you have the right to appeal the decision. If you would like a copy of a benefit booklet providing more information about our Utilization Management programs, call the toll free number listed in your information packet.

Certification

Certification is a program designed to make sure that your care is given in a cost effective setting and efficient manner. If you need to be hospitalized, you must obtain certification. Non-emergency and non-maternity hospital admissions must be certified prior to the hospitalization. If the admission is not certified, a penalty will be applied.

For maternity admissions, your provider is not required to obtain certification from BCBSNC for prescribing a length of stay up to 48 hours for a normal vaginal delivery, or up to 96 hours for delivery by cesarean section. Your or your provider must request certification for coverage for additional days, which will be given by BCBSNC, if medically necessary.

All inpatient and certain outpatient Mental Health and Substance Abuse services must be certified in advance by Magellan Behavioral Health. Call Magellan Behavioral Health at 1-800-359-2422. Office visits do not require certification.

In-network providers are responsible for obtaining certifications. The member will bear no financial penalties if the in-network provider fails to obtain the appropriate authorization. The member is responsible for obtaining certification for services rendered by an out-of-network or out-of-state provider.

Health and Wellness Program

Because we want to help you stay healthy, we offer a variety of wellness benefits and services. You can take advantage of HealthLine Blue, our 24 hour health information service, a health topics library, asthma and diabetes management and a prenatal program. You will also have access to online health and wellness information at www.bcbsnc.com. With our program you can get health advice anytime you need it, so you can learn how to take charge of your health.

What is Not Covered?

The following are summaries of some of the coverage restrictions. A full explanation and listing of restrictions will be found in your benefit booklet.

Your health benefit plan does not cover services, supplies, drugs or charges that are:

- Not medically necessary
- For injury of illness resulting from an act of war
- For personal hygiene and convenience items
- For inpatient admissions that are primarily for diagnostic studies
- For palliative or cosmetic foot care
- For investigative or experimental purposes
- For hearing aids or tinnitus maskers, except as Specifically covered by the benefit plan
- For cosmetic services or cosmetic surgery
- For custodial care, domiciliary care or rest cures
- For treatment of obesity, except for surgical treatment of morbid obesity, or as specifically covered by your health benefit plan
- For reversal of sterilization
- For treatment of sexual dysfunction not related to organic Disease
- For assisted reproductive technologies as defined by the Centers for Disease Control and Prevention
- For self-injectable drugs in the provider's office