

SUMMARY OF BENEFITS

This section provides a summary of your Blue Options benefits. A more complete description of your benefits is found in "Covered Services." General exclusions may also apply - please see "What Is Not Covered?" As you review the "Summary Of Benefits" chart, keep in mind:

- Copayment amounts are fixed dollar amounts the *member* must pay for some *covered services*
- Multiple *office visits* or emergency room visits on the same day may result in multiple copayments
- Coinsurance percentages shown in this section are part of the *allowed amount* that the *Plan* pays
- Deductible and coinsurance amounts are based on the *allowed amount*
- Services applied to the deductible also count toward any visit or day maximums
- To receive *in-network* benefits, you must receive care from a Blue Options *in-network provider*. **However, in an emergency, or when *in-network providers* are not reasonably available as determined by BCBSNC's access to care standards, you may also receive IN-NETWORK benefits for care from an *out-of-network provider*. Please see "Out-Of-Network Benefit Exceptions" and "Emergency Care" for more information. Access to care standards are available on the BCBSNC Web site at bcbsnc.com or by calling BCBSNC Customer Service at the number listed on your *ID Card* or in "Whom Do I Contact?"**
- If you see an *out-of-network provider*, you will receive *out-of-network* benefits unless otherwise approved by BCBSNC.

Please note: The list of *in-network providers* may change from time to time, so please verify that the *provider* is still in the Blue Options network before receiving care. Find a *provider* on the BCBSNC Web site at bcbsnc.com or call BCBSNC Customer Service at the number listed on your *ID card* or in "Whom Do I Contact?"

SPECIAL NOTICE IF YOU CHOOSE AN *OUT-OF-NETWORK PROVIDER*

Your actual expenses for *Covered Services* may exceed the stated coinsurance percentage or copayment amount because actual *provider* charges may not be used to determine the *Plan's* and *member's* payment obligations. For *out-of-network* benefits, you may be required to pay for charges over the *allowed amount*, in addition to any copayment or coinsurance amount.

SUMMARY OF BENEFITS (cont.)

Benefit period - July 1, 2011 through June 30, 2012

Benefit payments are based on where services are received and how services are billed.

Benefits	In-Network	Out-Of-Network
<p>Provider's Office See Outpatient Services for <i>outpatient clinic</i> or <i>hospital</i>-based services. <i>Office visits</i> for the evaluation and treatment of obesity are limited to a combined in- and <i>out-of-network</i> maximum of four visits per <i>benefit period</i>. Any visits in excess of these <i>benefit period</i> maximums are not <i>covered services</i>.</p>		
<p>Office Visit Services</p> <p style="text-align: right;">Primary Care Provider \$15 copayment 80%</p> <p style="text-align: right;">Specialist \$30 copayment 80%</p> <p>Includes office <i>surgery</i>, x-rays and lab tests.</p> <p>CT Scans, MRIs, MRAs and PET Scans (received 100% 80% in any location, including doctor's office)</p>		
<p>Preventive Care Services This benefit is only for services that indicate a diagnosis of preventive or wellness. Also see "<i>Preventive Care</i>" in "<i>Covered Services</i>."</p> <p>Preventive Care 100% 70%</p> <p>This includes: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, bone mass measurement, prostate-specific antigen tests, and newborn hearing screening.</p> <p>Immunizations/ALL Flu Shots 100% 100%</p> <p>Immunizations for International Travel \$15 copayment, \$15 copayment, then 100% then 100%</p> <p>Other <i>Preventive Care</i> 100% Benefits not available</p>		
<p>Therapy Services</p> <p>Short-term Rehabilitative Therapies \$30 copayment 80%</p> <p>Chiropractic Services \$15 copayment 80%</p> <p>Combined in- and <i>out-of-network benefit period maximums</i> apply to home, office and outpatient settings. 40 visits per <i>benefit period</i> for physical/occupational therapy. 30 visits per <i>benefit period</i> for chiropractic services, regardless of diagnosis, including maintenance. 40 visits per <i>benefit period</i> for speech therapy. Any visits in excess of these <i>benefit period</i> maximums are not <i>covered services</i>.</p>		
<p>Other Therapies 100% 80%</p> <p>Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See Outpatient Services for <i>other therapies</i> provided in an outpatient setting.</p>		

SUMMARY OF BENEFITS (cont.)

Benefits	In-Network	Out-Of-Network
Infertility Services		
<i>Primary Care Provider</i>	\$15 copayment	80%
<i>Specialist</i>	\$30 copayment	80%
<p>Combined in- and out-of-network lifetime maximum of \$5,000 per member for infertility services, provided in all places of service. Any services in excess of this lifetime maximum are not covered services.</p>		
Urgent Care Centers and Emergency Room		
Urgent Care Centers	\$15 copayment	\$15 copayment
<i>Preventive Care</i> services received in an <i>Urgent Care Center</i>	100%	Benefits not available, except for certain services covered at 70%
<p>This benefit is only for services that indicate a diagnosis of preventive or wellness. For a list of services, see "Preventive Care" in "Covered Services."</p>		
Emergency Room Visit (facility charge)	\$450 copayment	\$450 copayment
<p>If admitted to the hospital from the emergency room, the emergency room copayment does not apply; instead, inpatient hospital benefits apply to all covered services provided in both the emergency room and during inpatient hospitalization. If held for observation, the emergency room copayment does not apply; instead, outpatient benefits apply to all covered services provided in both the emergency room and during observation. If you are sent to the emergency room from an urgent care center, you may be responsible for both the emergency room copayment and the urgent care copayment.</p>		
Emergency Room Visit (professional charge)	100%	80%
Ambulatory Surgical Center		
Ambulatory Surgical Services	90%	80%
<i>Preventive Care Services</i>	100%	Benefits not available, except for certain services covered at 70%
<p>This benefit is only for services that indicate a diagnosis of preventive or wellness. For a list of services, see "Preventive Care" in "Covered Services."</p>		

SUMMARY OF BENEFITS (cont.)

Benefits	<i>In-Network</i>	<i>Out-Of-Network</i>
Outpatient		
Physician Services	90%	80%
Hospital and Hospital-based Services	90%	80%
Outpatient Clinic Services	90%	80%
Therapy Services	90%	80%
Includes <i>short-term rehabilitative therapies</i> and <i>other therapies</i> including dialysis; see <i>Provider's Office</i> for visit maximums.		
Preventive Care Services	100%	Benefits not available, except for certain services covered at 70%
This benefit is only for services that indicate a diagnosis of preventive or wellness. For a list of services, see "Preventive Care" in "Covered Services."		
Outpatient Diagnostic Services		
Outpatient lab tests and mammography, when performed alone (Physician and Hospital-based services)	100%	80%
Outpatient lab tests and mammography, when performed with another service		
Physician Services	100%	80%
Hospital and Hospital-based Services	90%	80%
Outpatient x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	100%	80%
CT scans, MRIs, MRAs and PET scans	100%	80%
Inpatient		
Physician Services (excluding Maternity)	90%	80%
Physician Services / Maternity	100% after a one-time \$15 copayment	80%
Hospital and Hospital-based Services	90%	80%
Includes maternity delivery, prenatal and post-delivery care. If you are in a <i>hospital</i> as an inpatient at the time you begin a new <i>benefit period</i> , you may have to meet a new deductible for <i>covered services</i> from <i>doctors</i> or <i>other professional providers</i> .		

SUMMARY OF BENEFITS (cont.)

Benefits	In-Network	Out-Of-Network
Skilled Nursing Facility		
<p>Combined in- and <i>out-of-network</i> maximum of 100 days per <i>benefit period</i> and 200 days per lifetime. Services applied to the deductible count towards this day maximum. Any services in excess of these <i>benefit period maximums</i> are not covered services.</p>	90%	80%
Other Services		
<p>Includes <i>ambulance, durable medical equipment, hospice services, medical supplies, orthotic devices, private duty nursing, prosthetic appliances, and home health care</i>. Any services in excess of these <i>benefit period or lifetime maximums</i> are not covered services.</p>	90%	80%
<p>Ambulance Ambulance charges do not require a deductible.</p>	100%	100%
<p>Cranial Bands For correction of <i>positional plagiocephaly</i>. Benefits subject to a combined in- and <i>out-of-network benefit period maximum</i> of \$600.</p>	100%	80%
<p>Diabetic Supplies, Spacers and Peak Flow Meters Available through a DME <i>provider</i>.</p>	100%	100%
<p>Hearing Exams Hearing hardware only covered with a combined in- and <i>out-of-network benefit period maximum</i> of \$2,000.</p>	100%	100%
<p>Foot Orthotics</p>	100% of billed amount	100% of billed amount

SUMMARY OF BENEFITS (cont.)

Benefits	<i>In-Network</i>	<i>Out-Of-Network</i>
Mental Health And Substance Abuse Services		
Mental Health Office Services	\$15 copayment	80%
Mental Health Inpatient Services		
Physician Services	90%	80%
<i>Hospital and Hospital-based Services</i>	90%	80%
Mental Health Outpatient Services		
Physician Services	90%	80%
<i>Hospital and Hospital-based Services</i>	90%	80%
Substance Abuse Office Services		
Substance Abuse Inpatient Services		
Physician Services	90%	80%
<i>Hospital and Hospital-based Services</i>	90%	80%
Substance Abuse Outpatient Services		
Physician Services	90%	80%
<i>Hospital and Hospital-based Services</i>	90%	80%

SUMMARY OF BENEFITS (cont.)

Benefits	In-Network	Out-Of-Network
Lifetime Maximum, Deductible, and Coinsurance Maximum		
<p>The following deductibles and maximums apply to the services listed above in the "Summary Of Benefits" unless otherwise noted.</p>		
<p>Lifetime Maximum</p>	<p>Unlimited</p>	<p>Unlimited</p>
<p>Unlimited for all services, except orthotic devices for <i>positional plagiocephaly</i> and <i>infertility</i>. If you exceed any <i>lifetime maximum</i>, additional services of that type are not covered. In this case, you may be responsible for the entire amount of the <i>provider's</i> billed charge.</p>		
<p>Deductible</p>		
<p>Individual, per <i>benefit period</i></p>	<p>\$0</p>	<p>\$0</p>
<p>Family, per <i>benefit period</i></p>	<p>\$0</p>	<p>\$0</p>
<p>Coinsurance Maximum</p>		
<p>Individual, per <i>benefit period</i></p>	<p>\$1,500</p>	<p>\$3,000</p>
<p>Family, per <i>benefit period</i></p>	<p>\$3,000</p>	<p>\$6,000</p>
<p>Certification Requirements</p>		
<p>Certain services, regardless of the location, require <i>prior review</i> and <i>certification</i> by BCBSNC in order to receive benefits. If you go to an <i>in-network provider</i> in North Carolina, your <i>provider</i> will request <i>prior review</i> when necessary. If you go to an <i>out-of-network provider</i> in North Carolina or to any <i>provider</i> outside of North Carolina, you are responsible for requesting or ensuring that your <i>provider</i> requests <i>prior review</i> by BCBSNC. Failure to request <i>prior review</i> and receive <i>certification</i> may result in allowed charges being reduced by 25% or a full denial of benefits. See "Covered Services" and "Prospective Review/Prior Review" in "Utilization Management."</p>		
<p>The <i>Plan</i> delegates administration of your mental health and substance abuse benefits to Magellan Behavioral Health. Magellan Behavioral Health is not associated with BCBSNC. <i>Prior review</i> and <i>certification</i> by Magellan Behavioral Health are required for inpatient and certain outpatient mental health and substance abuse services received from an <i>in-network provider</i>, except for <i>emergencies</i>. Please see the number in "Whom Do I Contact?"</p>		