

## **PPO BASIC PLAN SUMMARY OF BENEFITS**

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The following is a summary of your *PPO* Basic Plan benefits. A more complete description of your benefits is found in "*Covered Services*." General exclusions may also apply. Please see "What Is Not Covered?"

- The *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 the portion of the *allowed amount* that you pay
- *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 Benefits*" and "*Emergency And Urgent Care Services*" for additional information on *emergency* care. Access to care standards are available on our web site at [www.shpnc.org](http://www.shpnc.org) or by calling the *State Health Plan* Customer Services number given in "Whom Do I Call?"
- If you see an *out-of-network provider*, you will receive *out-of-network* benefits unless otherwise approved by the *State Health Plan* or its representative.

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. *Provider* directories are available through our web site at [www.shpnc.org](http://www.shpnc.org) or by calling *State Health Plan* Customer Services at the number given in "Whom Do I Call?"

View the following pages for an important overview of changes to your benefits effective July 1, 2009.

## The North Carolina State Health Plan for Teachers and State Employees Plan Comparisons

Plan Design Feature	Basic (70/30)		Standard (80/20)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Lifetime Maximum</b>	Unlimited	Unlimited	Unlimited	Unlimited
<b>Benefit Year Deductible</b>	<b>\$800</b> Individual <b>\$2,400</b> Family	<b>\$1,600</b> Individual <b>\$4,800</b> Family	<b>\$600</b> Individual <b>\$1,800</b> Family	<b>\$1,200</b> Individual <b>\$3,600</b> Family
<b>Plan Coinsurance</b>	30% of eligible expenses after deductible	50% of eligible expenses after deductible <b>and the difference between the allowed amount and the charge</b>	20% of eligible expenses after deductible	40% of eligible expenses after deductible <b>and the difference between the allowed amount and the charge</b>
<b>Coinsurance Maximum (does not include deductible)</b>	<b>\$3,250</b> Individual <b>\$9,750</b> Family	<b>\$6,500</b> Individual <b>\$19,500</b> Family	<b>\$2,750</b> Individual <b>\$8,250</b> Family	<b>\$5,500</b> Individual <b>\$16,500</b> Family
<b>Office Visits</b>	<b>\$30<sup>1</sup></b> copay primary care <b>\$70<sup>1</sup></b> copay specialist	50% coinsurance after deductible	<b>\$25<sup>1</sup></b> copay primary care <b>\$60<sup>1</sup></b> copay specialist	40% coinsurance after deductible
<b>Urgent Care</b>	<b>\$75</b> copay	Same as in-network benefit	<b>\$75</b> copay	Same as in-network benefit
<b>Emergency Room</b>	<b>\$250</b> copay plus 30% coinsurance after deductible	Same as in-network benefit	<b>\$200</b> copay plus 20% coinsurance after deductible	Same as in-network benefit
<b>Inpatient</b>	<b>\$250</b> copay plus 30% coinsurance after deductible	<b>\$250</b> copay then 50% coinsurance after deductible	<b>\$200</b> copay plus 20% coinsurance after deductible	<b>\$200</b> copay then 40% coinsurance after deductible
<b>Outpatient Hospital and Ambulatory Surgical Center</b>	30% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
<b>Preventive Care</b>	<b>\$30<sup>1</sup></b> copay primary care <b>\$70<sup>1</sup></b> copay specialist	Not covered <sup>2</sup>	<b>\$25<sup>1</sup></b> copay primary care <b>\$60<sup>1</sup></b> copay specialist	Not covered <sup>2</sup>
<b>Short Term Therapies Physical/Occupational/Speech (PT/OT/ST)</b>	<b>\$55<sup>1</sup></b> copay - office services 30% coinsurance after deductible - outpatient hospital	50% coinsurance after deductible	<b>\$45<sup>1</sup></b> copay - office services 20% coinsurance after deductible - outpatient hospital	40% coinsurance after deductible
<b>Chiropractic (Chiro)</b>	<b>\$55<sup>1</sup></b> copay - 30 visit limit per benefit period	50% coinsurance after deductible	<b>\$45<sup>1</sup></b> copay - 30 visit limit per benefit period	40% coinsurance after deductible
<b>Routine Eye Exam<sup>3</sup></b>	<b>\$30</b> copay	Not covered	<b>\$25</b> copay	Not covered
<b>Mental Health/Substance Abuse (MH/SA)</b>				
<b>Office Services</b>	<b>\$55<sup>1</sup></b> copay	50% coinsurance	<b>\$45<sup>1</sup></b> copay	40% coinsurance
<b>Outpatient Services</b>	30% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
<b>Inpatient Services</b>	<b>\$250</b> copay then 30% coinsurance after deductible	<b>\$250</b> copay then 50% coinsurance after deductible	<b>\$200</b> copay then 20% coinsurance after deductible	<b>\$200</b> copay then 40% coinsurance after deductible
	Prior authorization is required after 26-combined in and out-of-network office visits		Prior authorization is required after 26-combined in and out-of-network office visits	
<b>Generic Rx</b>	<b>\$10</b> copay for 30 day supply		<b>\$10</b> copay for 30 day supply	
<b>Preferred Brand Rx (no generic equivalent)</b>	<b>\$35</b> copay for 30 day supply		<b>\$35</b> copay for 30 day supply	
<b>Non-Preferred Brand Rx (no generic equivalent)</b>	<b>\$55</b> copay for 30 day supply		<b>\$55</b> copay for 30 day supply	
	For brand name drugs with an available generic, members will be required to pay the generic copay, plus the difference between the Plan's cost of the brand name drug and the Plan's cost of the generic drug.			
<b>Specialty Rx<sup>4</sup></b>	25% coinsurance up to <b>\$100</b> for each 30 day supply		25% coinsurance up to <b>\$100</b> for each 30 day supply	
<b>Diabetic Supplies<sup>5</sup></b>	<b>\$10</b> copay for preferred brand for 30 day supply <b>\$25</b> copay for non-preferred brand for 30 day supply		<b>\$10</b> copay for preferred brand for 30 day supply <b>\$25</b> copay for non-preferred brand for 30 day supply	

1. In-network hospital owned or operated practices may be subject to deductible and coinsurance. Please call your physician or see the Provider Directory to determine if your physician's practice is hospital owned or operated.  
2. The following preventive care benefits are available both in and out-of-network: gynecological exams, cervical cancer screenings, ovarian cancer screening, screening mammograms, colorectal screening and prostate specific antigen tests.  
3. Routine eye exams as of January 1, 2010 will no longer be covered. Check with your Health Benefits Representative about your benefit options for vision.  
4. All non-acute specialty drugs, excluding cancer medications, must be obtained through the Accredo specialty pharmacy.  
5. For a single copay, insulin dependent members will receive 150 test strips and non-insulin dependent members receive 50 test strips per 30 day supply. Additional test strips needed are covered under the medical supply benefit.

# PPO BASIC PLAN SUMMARY OF BENEFITS

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

	<i>In-Network</i>	<i>Out-of-network*</i>
<b>Physician Office Services</b>		
See <i>Outpatient Services</i> 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> . Nutritional counseling for diabetes management is limited to six visits per <i>benefit period</i> .		
<b>Office Services</b>		
<i>Primary Care Provider</i>	\$25 <i>copayment</i>	50% after <i>deductible</i>
<i>Specialist</i>	\$50 <i>copayment</i>	50% after <i>deductible</i>
Includes office <i>surgery</i> , x-rays and lab tests. For MRIs, MRAs, CT scans and PET scans, see <i>Outpatient Diagnostic Services</i> .		
<b>CT Scans, MRI's, MRA's, and PET Scans</b>	<b>30% after deductible</b>	<b>50% after deductible</b>
<b>Preventive Care</b>		
<i>Primary Care Provider</i>	\$25 <i>copayment</i>	<b>Benefits not available<sup>1</sup></b>
<i>Specialist</i>	\$50 <i>copayment</i>	<b>Benefits not available<sup>1</sup></b>
Includes routine physical exams, well baby, well child care, and immunizations.		
<b>The following preventive care benefits are available both in- and out-of-network: gynecological exams, cervical cancer screening, ovarian cancer screening, screening mammograms, colorectal screening, and prostate specific antigen tests. See "Covered Services."</b>		
<b>Short-Term Rehabilitative Therapies</b>	\$50 <i>copayment</i>	50% after <i>deductible</i>
Limited to rehabilitative speech, physical, and occupational therapy.		
<b>Chiropractic Services</b>	\$50 <i>copayment</i>	50% after <i>deductible</i>
Combined in- and <i>out-of-network benefit period maximum</i> of 30 visits per <i>benefit period</i> .		
<b>Other Therapies</b>	100%	50% after <i>deductible</i>
Includes chemotherapy, dialysis and cardiac rehabilitation provided in the office. See <i>Outpatient Services</i> for <i>other therapies</i> provided in an <i>outpatient</i> setting.		
<b>Infertility and Sexual Dysfunction Services</b>		
<i>Primary Care Provider</i>	\$25 <i>copayment</i>	50% after <i>deductible</i>
<i>Specialist</i>	\$50 <i>copayment</i>	50% after <i>deductible</i>
Combined in- and <i>out-of-network lifetime maximum</i> of \$5,000 per <i>member</i> , provided in all places of service.		
<b>Routine Eye Exam</b>	\$25 <i>copayment</i>	<b>Benefits not available</b>
<b>Routine Hearing Evaluation Test:</b>		
<i>Primary Care Provider</i>	\$25 <i>copayment</i>	<b>Benefits not available</b>
<i>Specialist</i>	\$50 <i>copayment</i>	<b>Benefits not available</b>

\*The following notice applies only when you are responsible for obtaining *certification*. NOTICE: 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*. In addition, certain services require prior approval in advance. You are responsible for obtaining or having your *provider* obtain prior plan approval on your behalf if you go to an *out-of-network*, or out-of-state *provider*, or for mental health and chemical dependency visits 27 and beyond. Failure to obtain prior plan approval could result in partial or full denial of benefits.

## **PPO BASIC PLAN SUMMARY OF BENEFITS**

	<b><i>In-Network</i></b>	<b><i>Out-of-Network</i></b>
<b><u>Urgent Care Centers and Emergency Room</u></b>		
<b><i>Urgent Care Centers</i></b>	\$75 <i>copayment</i>	\$75 <i>copayment</i>
<b><i>Emergency Room Visit</i></b>	\$250 <i>copayment</i> , then 30% after <i>deductible</i>	\$250 <i>copayment</i> , then 30% after <i>deductible</i>
If admitted to the <i>hospital</i> from the <i>emergency room</i> , <i>inpatient hospital</i> benefits apply to all covered services provided, and the <i>emergency room copayment</i> is waived. If held for observation, <i>outpatient</i> benefits apply to all covered services provided. If you are sent to the <i>emergency room</i> from an <i>Urgent Care Center</i> , you may be responsible for both the <i>emergency room copayment</i> and the <i>urgent care copayment</i> .		
<b><u>Ambulatory Surgical Center</u></b>	30% after <i>deductible</i>	50% after <i>deductible</i>
<b><u>Outpatient Services</u></b>		
<b><i>Physician Services</i></b>	30% after <i>deductible</i>	50% after <i>deductible</i>
<b><i>Hospital and Hospital Based Services</i></b>	30% after <i>deductible</i>	50% after <i>deductible</i>
<b><i>Outpatient Clinic Services</i></b>	30% after <i>deductible</i>	50% after <i>deductible</i>
<b><i>Outpatient Diagnostic Services:</i></b>		
<i>Outpatient</i> lab tests and mammography, when performed alone	Covered at 100%	50% after <i>deductible</i>
<i>Outpatient</i> lab tests and mammography, when performed with another service	30% after <i>deductible</i>	50% after <i>deductible</i>
<i>Outpatient</i> x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	30% after <i>deductible</i>	50% after <i>deductible</i>
CT scans, MRIs, MRAs and PET scans received in any location, including in a physician's office	30% after <i>deductible</i>	50% after <i>deductible</i>
<b><i>Therapy Services</i></b>	30% after <i>deductible</i>	50% after <i>deductible</i>
Includes <i>short-term rehabilitative therapies</i> and <i>other therapies</i> . See Physician Office Services for visit maximums.		
<b><u>Inpatient Hospital Services</u></b>		
<b><i>Physician Services</i></b>	30% after <i>deductible</i>	50% after <i>deductible</i>
<b><i>Hospital and Hospital based Services</i></b>	\$200 <i>copayment</i> , then 30% after <i>deductible</i>	\$200 <i>copayment</i> , then 50% after <i>deductible</i>
Includes maternity delivery, prenatal and post-delivery care. For <i>inpatient</i> mental health and chemical dependency services, refer to the "Mental Health And Substance Abuse Services" section later in this summary.		
<b><u>Skilled Nursing Facility</u></b>	30% after <i>deductible</i>	50% after <i>deductible</i>
Combined in- and <i>out-of-network</i> maximum of 100 days per <i>benefit period</i> . Services applied to the <i>deductible</i> count towards this day maximum.		

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## **PPO BASIC PLAN SUMMARY OF BENEFITS**

	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Other Services</b>	30% after deductible	50% after deductible
Includes ambulance, durable medical equipment, hospice services, medical supplies, orthotic devices — Orthotic devices for correction of positional plagiocephaly limited to a lifetime maximum of \$600- prosthetic appliances, and home health care.		
<b>Private Duty Nursing</b>	30% after deductible	50% after deductible
There is a 4 hour per day limit on private duty nursing care for non-ventilated patients and a 12 hour per day limit on private duty nursing for ventilated patients.		

### **Lifetime Maximum, Deductible, and Coinsurance Maximum**

The following deductibles and maximums apply to the services listed above in the "Summary Of Benefits" unless otherwise noted.

<b>Lifetime Maximum</b>	Unlimited	Unlimited
Unlimited for all services, except orthotic devices for positional plagiocephaly, infertility and sexual dysfunction and substance abuse treatment, and where otherwise specifically excluded.		

#### **Deductible**

Individual, per benefit period	\$600	\$1,200
Family, per benefit period	\$1,800	\$3,600

Charges for the following do not apply to the benefit period deductible:

- Office visit copayments, emergency room copayments and inpatient admissions copayments.
- Inpatient newborn care for well-baby
- Prescription drugs

#### **Coinsurance Maximum**

Individual, per benefit period	\$2,500	\$5,000
Family, per benefit period	\$7,500	\$15,000

Charges for the following do not apply to the benefit period coinsurance maximum:

- Prescription drugs
- Deductible
- Office visit copayments
- Emergency room copayments
- Inpatient admission copayments

### **Penalty for Failure to Obtain Certification**

Certain services require prior review and certification by the State Health Plan in order to receive benefits. You are responsible for obtaining certification for mental health and chemical dependency for office visits beyond the 26<sup>th</sup> visit. For all other in-network services provided in North Carolina, your provider will request prior review when necessary. **If you go to an out-of-network provider in North Carolina or any provider outside of North Carolina, you are responsible for requesting or ensuring that your provider requests prior review by the State Health Plan. Failure to request prior review and receive certification may result in allowed charges being reduced by 25% or a full denial of benefits. Certification is not a guarantee of payment. See "Covered Services" and "Prospective Review/Prior Review" in "Utilization Management."**

\*The following notice applies only when you are responsible for obtaining certification. NOTICE: 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. In addition, certain services require prior approval in advance. You are responsible for obtaining or having your provider obtain prior plan approval on your behalf if you go to an out-of-network, or out-of-state provider, or for mental health and chemical dependency visits 27 and beyond. Failure to obtain prior plan approval could result in partial or full denial of benefits.

# PPO BASIC PLAN SUMMARY OF BENEFITS

## *In-Network*

## *Out-of-Network*

### Mental Health And Chemical Dependency Services

#### **Mental Health/Chemical Dependency Office Services**

\$50 *copayment*

50%

First 26 combined mental health and chemical dependency visits each *benefit period* do not require *prior review* by the *Mental Health Case Manager*. (The first 26 visits can include 6 preventive visits per *benefit period*. For visits 27 and beyond each *benefit period* it is your responsibility to obtain prior approval from the *Mental Health Case Manager*. Medication checks do not require prior approval.

#### **Mental Health/Chemical Dependency Outpatient Services**

30% after *deductible*

50% after *deductible*

#### **Mental Health/Chemical Dependency Inpatient Services**

\$200 *copayment*, then 30% after *deductible*

\$200 *copayment*, then 50% after *deductible*

#### **Residential Treatment Centers**

\$200 *copayment*, then 30% after *deductible*

\$200 *copayment*, then 50% after *deductible*

Requires *certification* and *prior review* in advance by the *Mental Health Case Manager*, and must be an approved residential treatment center.

### Prescription Drugs

*Prescription drug* benefits are administered by Medco. See "*Prescription Drug Copayment And Benefits*" in "*Covered Services*" for more information. Diabetic supplies are covered under the pharmacy benefit but once limits have been met, supplies are then covered under the medical supply benefit. Contact Medco at the number given in "Whom Do I Call?"

	<b>0-34 Days Supply</b>	<b>35-68 Days Supply</b>	<b>69-102 Days Supply</b>
<b>Generic</b>	\$10	\$20	\$30
<b>Preferred Brand</b> (without <i>generic</i> available)	\$30	\$60	\$90
<b>Preferred Brand</b> (with <i>generic</i> available)	\$40	\$80	\$120
<b>Non-Preferred Brand</b>	\$50	\$100	\$150
<b>Diabetic Testing Supplies</b>			
<b>Preferred brand</b>	\$10	\$20	\$30
<b>Non-preferred brand</b>	\$25	\$50	\$75

*Prescription drug copayments* are limited to \$2,500 per person per *benefit period*. After the \$2,500 maximum is reached, the health benefit plan pays 100% of allowed *prescription drug* charges.

For *certification* for certain *prescription drugs*, your physician may call Medco at 1-800-753-2851 to initiate a *certification* request, or obtain a *certification* review form on the *State Health Plan's* web site and fax it directly to Medco at the number listed on the form.

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