

## **PPO PLUS PLAN SUMMARY OF BENEFITS**

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The following is a summary of your *PPO Plus* 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 towards 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?"**

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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>	\$15 <i>copayment</i>	30% after <i>deductible</i>
<i>Specialist</i>	\$30 <i>copayment</i>	30% 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>10% after deductible</b>	<b>30% after deductible</b>
<b>Preventive Care</b>		
<i>Primary Care Provider</i>	\$15 <i>copayment</i>	<b>Benefits not available<sup>1</sup></b>
<i>Specialist</i>	\$30 <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>	\$30 <i>copayment</i>	30% after <i>deductible</i>
Limited to rehabilitative speech, physical, and occupational therapy.		
<b>Chiropractic Services</b>	\$30 <i>copayment</i>	30% 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%	30% 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>	\$15 <i>copayment</i>	30% after <i>deductible</i>
<i>Specialist</i>	\$30 <i>copayment</i>	30% 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>	\$15 <i>copayment</i>	<b>Benefits not available</b>
<b>Routine Hearing Evaluation Test:</b>		
<i>Primary Care Provider</i>	\$15 <i>copayment</i>	<b>Benefits not available</b>
<i>Specialist</i>	\$30 <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.

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	<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>	\$50 <i>copayment</i>	\$50 <i>copayment</i>
<b><i>Emergency Room Visit</i></b>	\$150 <i>copayment</i> , then 10% after <i>deductible</i>	\$150 <i>copayment</i> , then 10% after <i>deductible</i>
If admitted to the <i>hospital</i> from the emergency room, <i>inpatient hospital</i> benefits apply to all covered services provided, and the emergency room <i>copayment</i> is waived. If held for observation, <i>outpatient</i> benefits apply to all covered services provided. If you are sent to the emergency room from an <i>Urgent Care Center</i> , you may be responsible for both the emergency room <i>copayment</i> and the <i>urgent care copayment</i> .		
<b><u>Ambulatory Surgical Center</u></b>	10% after <i>deductible</i>	30% after <i>deductible</i>
<b><u>Outpatient Services</u></b>		
<b><i>Physician Services</i></b>	10% after <i>deductible</i>	30% after <i>deductible</i>
<b><i>Hospital and Hospital Based Services</i></b>	10% after <i>deductible</i>	30% after <i>deductible</i>
<b><i>Outpatient Clinic Services</i></b>	10% after <i>deductible</i>	30% after <i>deductible</i>
<b><i>Outpatient Diagnostic Services:</i></b>		
<i>Outpatient</i> lab tests and mammography, when performed alone	Covered at 100%	30% after <i>deductible</i>
<i>Outpatient</i> lab tests and mammography, when performed with another service	10% after <i>deductible</i>	30% after <i>deductible</i>
<i>Outpatient</i> x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	10% after <i>deductible</i>	30% after <i>deductible</i>
CT scans, MRIs, MRAs and PET scans received in any location, including in a physician's office	10% after <i>deductible</i>	30% after <i>deductible</i>
<b><i>Therapy Services</i></b>	10% after <i>deductible</i>	30% 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>	10% after <i>deductible</i>	30% after <i>deductible</i>
<b><i>Hospital and Hospital based Services</i></b>	\$100 <i>copayment</i> , then 10% after <i>deductible</i>	\$100 <i>copayment</i> , then 30% 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 Chemical Dependency Services" section later in this summary.		
<b><u>Skilled Nursing Facility</u></b>	10% after <i>deductible</i>	30% 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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	<b><i>In-Network</i></b>	<b><i>Out-of-Network</i></b>
<b><u>Other Services</u></b>	10% after <i>deductible</i>	30% after <i>deductible</i>
Includes <i>ambulance, durable medical equipment, hospice services, medical supplies, orthotic devices</i> — Orthotic devices for correction of <i>positional plagiocephaly</i> limited to a <i>lifetime maximum</i> of \$600- <i>prosthetic appliances, and home health care.</i>		
<b><u>Private Duty Nursing</u></b>	10% after <i>deductible</i>	30% after <i>deductible</i>
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.		

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### **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><u>Lifetime Maximum</u></b>	Unlimited	Unlimited
Unlimited for all services, except orthotic devices for <i>positional plagiocephaly, infertility and sexual dysfunction, and chemical dependency treatment, and where otherwise specifically excluded.</i>		

### **Deductible**

Individual, per <i>benefit period</i>	\$150	\$300
Family, per <i>benefit period</i>	\$450	\$900

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 <i>benefit period</i>	\$1,000	\$2,000
Family, per <i>benefit period</i>	\$3,000	\$6,000

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*
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### **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*."**

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# PPO PLUS PLAN SUMMARY OF BENEFITS

## In-Network

## Out-of-Network

### Mental Health And Chemical Dependency Services

#### Mental Health/Chemical Dependency Office Services

\$30 *copayment*

30%

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

10% after *deductible*

30% after *deductible*

#### Mental Health/Chemical Dependency Inpatient Services

\$100 *copayment*, then 10% after *deductible*

\$100 *copayment*, then 30% after *deductible*

#### Residential Treatment Centers

\$100 *copayment*, then 10% after *deductible*

\$100 *copayment*, then 30% 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?"

	0-34 Days Supply	35-68 Days Supply	69-102 Days Supply
<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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