

PPO STANDARD PLAN SUMMARY OF BENEFITS

The following is a summary of your *PPO* Standard 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 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 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
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Benefit Year Deductible	\$800 Individual \$2,400 Family	\$1,600 Individual \$4,800 Family	\$600 Individual \$1,800 Family	\$1,200 Individual \$3,600 Family
Plan Coinsurance	30% of eligible expenses after deductible	50% of eligible expenses after deductible and the difference between the allowed amount and the charge	20% of eligible expenses after deductible	40% of eligible expenses after deductible and the difference between the allowed amount and the charge
Coinsurance Maximum (does not include deductible)	\$3,250 Individual \$9,750 Family	\$6,500 Individual \$19,500 Family	\$2,750 Individual \$8,250 Family	\$5,500 Individual \$16,500 Family
Office Visits	\$30 ¹ copay primary care \$70 ¹ copay specialist	50% coinsurance after deductible	\$25 ¹ copay primary care \$60 ¹ copay specialist	40% coinsurance after deductible
Urgent Care	\$75 copay	Same as in-network benefit	\$75 copay	Same as in-network benefit
Emergency Room	\$250 copay plus 30% coinsurance after deductible	Same as in-network benefit	\$200 copay plus 20% coinsurance after deductible	Same as in-network benefit
Inpatient	\$250 copay plus 30% coinsurance after deductible	\$250 copay then 50% coinsurance after deductible	\$200 copay plus 20% coinsurance after deductible	\$200 copay then 40% coinsurance after deductible
Outpatient Hospital and Ambulatory Surgical Center	30% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Preventive Care	\$30 ¹ copay primary care \$70 ¹ copay specialist	Not covered ²	\$25 ¹ copay primary care \$60 ¹ copay specialist	Not covered ²
Short Term Therapies Physical/Occupational/Speech (PT/OT/ST)	\$55 ¹ copay - office services 30% coinsurance after deductible - outpatient hospital	50% coinsurance after deductible	\$45 ¹ copay - office services 20% coinsurance after deductible - outpatient hospital	40% coinsurance after deductible
Chiropractic (Chiro)	\$55 ¹ copay - 30 visit limit per benefit period	50% coinsurance after deductible	\$45 ¹ copay - 30 visit limit per benefit period	40% coinsurance after deductible
Routine Eye Exam ³	\$30 copay	Not covered	\$25 copay	Not covered
Mental Health/Substance Abuse (MH/SA)				
Office Services	\$55 ¹ copay	50% coinsurance	\$45 ¹ copay	40% coinsurance
Outpatient Services	30% coinsurance after deductible	50% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Inpatient Services	\$250 copay then 30% coinsurance after deductible	\$250 copay then 50% coinsurance after deductible	\$200 copay then 20% coinsurance after deductible	\$200 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	
Generic Rx	\$10 copay for 30 day supply		\$10 copay for 30 day supply	
Preferred Brand Rx (no generic equivalent)	\$35 copay for 30 day supply		\$35 copay for 30 day supply	
Non-Preferred Brand Rx (no generic equivalent)	\$55 copay for 30 day supply		\$55 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.			
Specialty Rx ⁴	25% coinsurance up to \$100 for each 30 day supply		25% coinsurance up to \$100 for each 30 day supply	
Diabetic Supplies ⁵	\$10 copay for preferred brand for 30 day supply \$25 copay for non-preferred brand for 30 day supply		\$10 copay for preferred brand for 30 day supply \$25 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.

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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>
Physician Office Services		
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> .		
Office Services		
<i>Primary Care Provider</i>	\$20 <i>copayment</i>	40% after <i>deductible</i>
<i>Specialist</i>	\$40 <i>copayment</i>	40% 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> .		
CT Scans, MRI's, MRA's, and PET Scans	20% after deductible	40% after deductible
Preventive Care		
<i>Primary Care Provider</i>	\$20 <i>copayment</i>	Benefits not available¹
<i>Specialist</i>	\$40 <i>copayment</i>	Benefits not available¹
Includes routine physical exams, well baby, well child care, and immunizations.		
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."		
Short-Term Rehabilitative Therapies	\$40 <i>copayment</i>	40% after <i>deductible</i>
Limited to rehabilitative speech, physical, and occupational therapy.		
Chiropractic Services	\$40 <i>copayment</i>	40% after <i>deductible</i>
Combined in- and <i>out-of-network benefit period maximum</i> of 30 visits per <i>benefit period</i> .		
Other Therapies	100%	40% 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.		
Infertility and Sexual Dysfunction Services		
<i>Primary Care Provider</i>	\$20 <i>copayment</i>	40% after <i>deductible</i>
<i>Specialist</i>	\$40 <i>copayment</i>	40% 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.		
Routine Eye Exam	\$20 <i>copayment</i>	Benefits not available
Routine Hearing Evaluation Test:		
<i>Primary Care Provider</i>	\$20 <i>copayment</i>	Benefits not available
<i>Specialist</i>	\$40 <i>copayment</i>	Benefits not available

*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 STANDARD PLAN SUMMARY OF BENEFITS

	<i>In-Network</i>	<i>Out-of-Network</i>
<u>Urgent Care Centers and Emergency Room</u>		
Urgent Care Centers	\$50 copayment	\$50 copayment
Emergency Room Visit	\$200 copayment, then 20% after deductible	\$200 copayment, then 20% after deductible
<p>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>.</p>		
<u>Ambulatory Surgical Center</u>	20% after deductible	40% after deductible
<u>Outpatient Services</u>		
Physician Services	20% after deductible	40% after deductible
Hospital and Hospital Based Services	20% after deductible	40% after deductible
Outpatient Clinic Services	20% after deductible	40% after deductible
Outpatient Diagnostic Services:		
<i>Outpatient</i> lab tests and mammography, when performed alone	Covered at 100%	40% after deductible
<i>Outpatient</i> lab tests and mammography, when performed with another service	20% after deductible	40% after deductible
<i>Outpatient</i> x-rays, ultrasounds, and other diagnostic tests, such as EEGs, EKGs and pulmonary function tests	20% after deductible	40% after deductible
CT scans, MRIs, MRAs and PET scans received in any location, including in a physician's office	20% after deductible	40% after deductible
Therapy Services	20% after deductible	40% after deductible
<p>Includes <i>short-term rehabilitative therapies</i> and <i>other therapies</i>. See Physician Office Services for visit maximums.</p>		
<u>Inpatient Hospital Services</u>		
Physician Services	20% after deductible	40% after deductible
Hospital and Hospital based Services	\$150 copayment, then 20% after deductible	\$150 copayment, then 40% after deductible
<p>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.</p>		
<u>Skilled Nursing Facility</u>	20% after deductible	40% after deductible
<p>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.</p>		

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PPO STANDARD PLAN SUMMARY OF BENEFITS

	In-Network	Out-of-Network
Other Services	20% after deductible	40% 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.		
Private Duty Nursing	20% after deductible	40% 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.

Lifetime Maximum	Unlimited	Unlimited
Unlimited for all services, except orthotic devices for positional plagiocephaly, infertility and sexual dysfunction and chemical dependency treatment, and where otherwise specifically excluded.		

Deductible

Individual, per benefit period	\$300	\$600
Family, per benefit period	\$900	\$1800

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	\$1,750	\$3,500
Family, per benefit period	\$5,250	\$10,500

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 26th 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 STANDARD PLAN SUMMARY OF BENEFITS

In-Network

Out-of-Network

Mental Health And Chemical Dependency Services

Mental Health/Chemical Dependency Office Services

\$40 *copayment*

40%

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

20% after *deductible*

40% after *deductible*

Mental Health/Chemical Dependency Inpatient Services

\$150 *copayment*, then 20% after *deductible*

\$150 *copayment*, then 40% after *deductible*

\$150 *copayment*, then 20% after *deductible*

\$150 *copayment*, then 40% after *deductible*

Residential Treatment Centers

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
Generic	\$10	\$20	\$30
Preferred Brand (without <i>generic</i> available)	\$30	\$60	\$90
Preferred Brand (with <i>generic</i> available)	\$40	\$80	\$120
Non-Preferred Brand	\$50	\$100	\$150
Diabetic Testing Supplies			
Preferred brand	\$10	\$20	\$30
Non-preferred brand	\$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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