

Blue OptionsSM Benefit Highlights (PPO)

Physician Office Services	In-network	Out-of-network ¹
Office Visit		
<i>Includes Office Surgery, Consultation, X-rays and Lab</i>		
Primary Care Provider	\$40 copayment	70% after deductible
Specialist	\$75 copayment	70% after deductible
Preventive Care		
<i>Routine Examinations, Well-Child Care, Immunizations, Pap Smears, Mammograms, Prostate Specific Antigen Tests (PSAs)</i>		
Primary Care Provider	\$40 copayment	Not Available*
Specialist	\$75 copayment	Not Available*
<i>*Pap Smears, Mammograms, and PSAs are covered Out-of-network.</i>		
Therapies		
<i>Short-term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):</i>		
<i>Physical/Occupational: 30 visits per Benefit Period</i>		
<i>Speech Therapy: 30 visits per Benefit Period</i>		
Primary Care Provider	\$40 copayment	70% after deductible
Specialist	\$75 copayment	70% after deductible
Urgent Care Centers and Emergency Room		
Urgent Care Centers	\$75 copayment	\$75 copayment
Emergency Room Visit (<i>copayment waived if admitted</i>)	\$150 copayment	\$150 copayment
Ambulatory Surgical Center	80% after deductible	70% after deductible
Inpatient and Outpatient Hospital Services		
Hospital and Hospital Based Services	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible
Hospital and Professional		
Outpatient Labs and Mammograms with surgery or other services.	80% after deductible	70% after deductible
Outpatient Labs and Mammograms without surgery or other services.	100%	70% after deductible
All other Diagnostic services including X-rays, CT scans and MRIs	80% after deductible	70% after deductible
Other Services		
Skilled Nursing Facility (<i>60 days per Benefit Period</i>)	80% after deductible	70% after deductible
Home Health Care, Ambulance, Durable Medical Equipment and Hospice	80% after deductible	70% after deductible
Maternity		
<i>Maternity Delivery includes Prenatal and Post-delivery care</i>		
Hospital Services (<i>Delivery</i>)	80% after deductible	70% after deductible
Professional Services (<i>Delivery</i>)	80% after deductible	70% after deductible
Transplants		
Hospital Services	80% after deductible	70% after deductible
Professional Services	80% after deductible	70% after deductible
Infertility and Sexual Dysfunction Services		
<i>Up to \$5,000 per Lifetime</i>		
Primary Care Provider	\$40 copayment	70% after deductible
Specialist	\$75 copayment	70% after deductible
Hospital Services	80% after deductible	70% after deductible
Inpatient and Outpatient Professional Services	80% after deductible	70% after deductible
Vision Care		
Comprehensive Eye Exam	\$40 copayment	Benefits not available

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Lifetime Maximum, Deductibles & Coinsurance Maximums	In-network	Out-of-network ¹
<i>The following Deductibles and Coinsurance Maximums only apply to the services on the previous page:</i>		
Lifetime Benefit Maximum	\$5,000,000	\$5,000,000
Deductibles		
Individual (per Benefit Period)	\$2,000	\$4,000
Family (per Benefit Period)	\$4,000	\$8,000
Coinsurance Maximum		
Individual (per Benefit Period)	\$3,000	\$6,000
Family (per Benefit Period)	\$9,000	\$18,000

Prescription Drugs

Up to 30 day supply. 31-60 day supply is two copayments and 61-90 day supply is three copayments. Infertility Drugs up to \$5,000 Lifetime Maximum.
MAC B Pricing, Brand Penalty

Tier 1 (Generic)	\$10 copayment	Copayment + charge over In-network allowed amount
Tier 2 (Preferred Brand)	\$35 copayment	Copayment + charge over In-network allowed amount
Tier 3 (Brand)	\$50 copayment	Copayment + charge over In-network allowed amount

Mental Health and Substance Abuse Services

**Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422.*

Mental Health Services

	Certified*	Not-Certified ¹
Office (20 visits per Benefit Period)	\$75 copayment	70% coinsurance
Inpatient/Outpatient (30 Days per Benefit Period)	80% coinsurance	70% coinsurance
Substance Abuse Services		
Office Visit	\$75 copayment	70% coinsurance
Inpatient/Outpatient	80% coinsurance	70% coinsurance
Benefit Period Maximum		\$8,000
Lifetime Maximum		\$16,000

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.

Atlantic Corporation of Wilmington

Effective Date: 10/2004

Quote Date: 04/13/2004