

# 2007 Blue ADVANTAGE<sup>®</sup> Plan Options

	Benefit period deductible	Coinsurance	Coinsurance maximum	Lifetime benefits	Physician office visits	Prescription drugs	Vision care
	The benefit period deductible is the amount you pay for some services before Blue Advantage pays its portion.	Coinsurance is the percentage of the allowed amounts for covered services that BCBSNC will pay.	Once your coinsurance maximum is met for in-network services, Blue Advantage covers 100% of all covered services for the rest of the benefit period.	A maximum amount paid for covered services which is the extent of the Plan's lifetime liability per member	Primary doctors & specialists (including surgery, lab work, therapy & radiology performed by the same doctor on the same day in office)	No annual limit for generic drugs (\$2,000 maximum for brand name drugs per person per benefit period)	Routine eye exam
<b>Our most popular plan</b>	<b>Plan A</b> In-network coverage <sup>1,2</sup> Deductible options: \$250, \$500, \$1,000 or \$2,500	<b>80% or 100%</b> (100% coinsurance is not available on the \$2,500 deductible option)	<b>100%</b> coinsurance plans: \$0 <b>80%</b> coinsurance plans: \$2,000 per individual, \$4,000 per family	Unlimited	<b>100%</b> after a <b>\$15</b> copay for primary physicians <sup>3</sup> or a <b>\$30</b> copay for specialists <sup>4</sup>	<b>100%</b> after <b>\$10</b> copay for generic, <b>\$35</b> copay for preferred brand, <b>\$50</b> copay for brand, or <b>25%</b> member coinsurance for specialty brand <sup>5</sup>	<b>100%</b> after a <b>\$15</b> copay
<b>For the budget-minded</b>	<b>Plan B</b> In-network coverage <sup>1,2</sup> Deductible options: \$500, \$1,000, \$2,500, \$3,500 or \$5,000	<b>70%</b>	\$3,000 per individual, \$6,000 per family	\$5 million	<b>100%</b> after a <b>\$25</b> copay for primary physicians <sup>3</sup> or a <b>\$50</b> copay for specialists <sup>4</sup>	<b>100%</b> after \$200 annual deductible per member, then <b>\$10</b> copay for generic, <b>\$35</b> copay for preferred brand, <b>\$50</b> copay for brand, or <b>25%</b> member coinsurance for specialty brand <sup>5</sup>	<b>Not available</b>
<b>Our newest low-cost plan</b>	<b>Plan C</b> In-network coverage <sup>1,2</sup> Deductible options: \$1,000, \$2,500, \$3,500 or \$5,000	<b>50%</b>	\$3,000 per individual, \$6,000 per family	\$5 million	<b>100%</b> after a <b>\$30</b> copay for primary physicians <sup>3</sup> or a <b>\$60</b> copay for specialists <sup>4</sup>	<b>100%</b> after \$500 annual deductible per member, then <b>\$10</b> copay for generic, <b>\$35</b> copay for preferred brand, <b>\$50</b> copay for brand, or <b>25%</b> member coinsurance for specialty brand <sup>5</sup>	<b>Not available</b>
	<b>Plan A, B &amp; C</b> Out-of-network coverage <sup>1,2</sup> Same as in-network	<b>Plan A: 70%</b> <b>Plan B: 60%</b> <b>Plan C: 40%</b>	When using out-of-network providers, your coinsurance maximum is twice the in-network coinsurance maximum	Same as in-network	<b>70%</b> after benefit period deductible	Same as in-network, plus the charges exceeding the allowed amount	<b>Not available</b>



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	Hospital care		Preventive care	Urgent care centers	Emergency room services	Ambulatory surgery centers	Mental health & substance abuse	Other services
	Inpatient facility, outpatient facility, drugs, blood, supplies, medical care, surgical care, therapy services, diagnostic tests, X-rays & lab work	Outpatient laboratory tests & mammograms performed alone	Routine physical exam, including gynecological exam; well-child and baby care (including periodic assessments and immunizations)	Services provided for a sudden or unexpected condition requiring prompt diagnosis or treatment to prevent chronic illness, prolonged impairment or a more hazardous treatment	Health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized	A licensed or certified nonhospital facility which has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis and does not provide inpatient accommodations	\$2,000 maximum per person per benefit period \$10,000 lifetime per person Inpatient facility, Inpatient professional, Outpatient professional	Durable medical equipment, home health care and home infusion therapy, hospice care, private duty nursing, ambulance services, skilled nursing facilities (to 60 days per year), dental accident
<b>Plan A</b> In-network coverage <sup>1,2</sup>	Coinsurance after benefit period deductible	<b>100%</b> with no deductible	<b>100%</b> after a <b>\$15</b> copay for primary physicians <sup>3</sup> or a <b>\$30</b> copay for specialists <sup>4</sup>	<b>100%</b> after a <b>\$30</b> copay	<b>100%</b> after a <b>\$150</b> copay <sup>7</sup> (copay waived if admitted)	Coinsurance after benefit period deductible	<b>50%</b> after benefit period deductible	Coinsurance after benefit period deductible
<b>Plan B</b> In-network coverage <sup>1,2</sup>	Coinsurance after benefit period deductible	<b>100%</b> with no deductible	<b>100%</b> after a <b>\$25</b> copay for primary physicians <sup>3</sup> or a <b>\$50</b> copay for specialists <sup>4</sup>	<b>100%</b> after a <b>\$50</b> copay	<b>100%</b> after a <b>\$150</b> copay <sup>7</sup> (copay waived if admitted)	Coinsurance after benefit period deductible	<b>50%</b> after benefit period deductible	Coinsurance after benefit period deductible
<b>Plan C</b> In-network coverage <sup>1,2</sup>	Coinsurance after benefit period deductible	<b>100%</b> with no deductible	<b>100%</b> after a <b>\$30</b> copay for primary physicians <sup>3</sup> or a <b>\$60</b> copay for specialists <sup>4</sup>	<b>100%</b> after a <b>\$60</b> copay	<b>100%</b> after a <b>\$150</b> copay <sup>7</sup> (copay waived if admitted)	Coinsurance after benefit period deductible	<b>50%</b> after benefit period deductible	Coinsurance after benefit period deductible
<b>Plan A, B &amp; C</b> Out-of-network coverage <sup>1,2</sup>	Coinsurance after benefit period deductible	Coinsurance after benefit period deductible	<b>Not available</b> <sup>6</sup>	<b>100%</b> after same copay as in-network	<b>100%</b> after a <b>\$150</b> copay <sup>7</sup> (copay waived if admitted)	Coinsurance after benefit period deductible	<b>50%</b> after benefit period deductible for Plans A and B <b>40%</b> after benefit period deductible for Plan C	Coinsurance after benefit period deductible



# Limitations & exclusions

Like most health care plans, Blue Advantage has some limitations and exclusions. When your application is approved, you will receive a benefit booklet. It will contain detailed information about plan benefits, exclusions and limitations.

## This is a partial list of benefits that are not payable:

- Services for or related to conception by artificial means or for reversal of sterilization
- Treatment of sexual dysfunction not related to organic disease
- Treatment for transsexualism, sex changes or modifications including surgery
- Services that are investigational in nature
- Services for complications or side effects arising from excluded services, procedures or treatments
- Services that are not medically necessary
- Dental care except as provided in your benefit booklet
- Services or expenses that are covered by any governmental unit except as required by Federal law
- Services received from an employer-sponsored dental or medical department
- Services received or hospital stays before the effective date of coverage
- Custodial care, domiciliary care or rest cures
- Eyeglasses or contact lenses or refractive eye surgery
- Vision exams except for some diagnoses (Plan B and C only)
- Services to correct nearsightedness or refractive errors; hearing aids, supplies, tinnitus maskers, or exams for hearing aids
- Services for cosmetic purposes
- Services for routine foot care
- Travel, except as specifically listed in the benefit booklet
- Services for weight control or reduction, except for morbid obesity
- Services for maternity or elective abortion, except as provided by the maternity option, if purchased
- Inpatient admissions that are primarily for physical therapy, diagnostic studies, or environmental change
- Services that are rendered by or on the direction of those other than doctors, hospitals, facility and professional providers; services that are in excess of the customary charge for services usually provided by one doctor when done by multiple doctors
- Services that are a result of war or while in military service
- Services for which a charge is not normally made in the absence of insurance, or services provided by an immediate relative
- Personal hygiene, comfort and/or convenience items
- Telephone consultations; charges for failure to keep scheduled visits, for completion of any form, or for medical information required by the plan
- Services primarily for educational purposes
- Services for conditions related to developmental delay and/or learning differences
- Long-term rehabilitative therapy
- Services not specifically listed as covered services

Your coverage will automatically renew. Your coverage may be canceled by Blue Cross and Blue Shield of North Carolina for failure to pay premiums and for false statements on your application, among other reasons. Coverage for dependent children ends at age 26. Members will be notified 30 days in advance of any change in coverage. A waiting period for coverage of pre-existing conditions may apply to your coverage.<sup>8</sup>

This brochure contains a summary of benefits only. It is not your insurance policy. Your policy is your insurance contract. If there is any difference between this brochure and the policy, the provisions of the policy will control.

**Please note:** Blue Advantage is not a High Deductible Health Plan (“HDHP”) under the Tax Code, and therefore is not intended to be paired with a Health Savings Account.

## Footnotes:

- 1 All services subject to the allowed amount.
- 2 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 payment obligations for BCBSNC and its members.
- 3 Primary physicians are in-network providers designated by BCBSNC as a primary care provider (PCP). Please check with BCBSNC to confirm your provider is in our network.
- 4 Some services and supplies received by members in an office setting or in connection with an office visit are in fact outpatient hospital-based services provided by hospital-owned or operated practices. These services and supplies may be subject to your deductible and coinsurance. Please see the provider listing to identify these providers.
- 5 Prescription drug benefits are divided into four drug-formulary tiers with varying copayment/coinsurance amounts based on the tier placement of a drug. Specific drug information can be found on the Prescription Drug Search tool at [bcbsnc.com](http://bcbsnc.com). Diabetic supplies are covered at 75% under the prescription drug benefit. In addition, benefits are provided for over-the-counter drugs when listed as covered in the formulary and a provider’s prescription for that drug is presented at the pharmacy.
- 6 Only gynecological exams, cervical cancer screenings, ovarian cancer screening, screening mammograms, colorectal screening and prostate specific antigen (PSA) tests are covered out-of-network subject to benefit period deductible and coinsurance.
- 7 If admitted to the hospital from the emergency room, inpatient hospital benefits apply to all covered services provided. If held for observation, outpatient benefits apply to all covered services provided. 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.
- 8 Pre-existing conditions are those for which medical advice, diagnosis, care or treatment was received or recommended within 12 months of the date that your Blue Advantage coverage begins. You may receive credit toward the 12-month waiting period if we receive your completed Blue Advantage application within 63 days of the termination of your previous health coverage.

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