

# 2007 Blue Options HSA Plans

Some benefit features are only available with certain plan combinations. Your premium will vary with the plan selected. Your benefits are listed in the same row as the coinsurance percentage you select.

## Individual (coverage for one person)

## Family (coverage for more than one person)

First,			Then,		Now,							
select your deductible			select your coinsurance for the deductible you choose		view your benefits							
Benefit period deductible <sup>1</sup>			Coinsurance		Prescription drugs <sup>2</sup>		Preventive care		Total Out-of-pocket maximum <sup>1</sup>		Annual contribution limit	
The benefit period deductible is the amount or expense for covered services that you must pay before your insurance benefits apply for all or part of the remaining cost of covered services.			Coinsurance is the percentage of the allowed amounts for covered services that BCBSNC will pay after you meet your deductible.		Unlimited coverage for generic drugs (combined in and out-of-network maximum of \$2,000 for brand name drugs per person per benefit period)		Routine physical exams and screening tests; well baby and child care (including periodic assessments and immunizations) <sup>3</sup>		Your maximum out-of-pocket expense, including your deductible and your share of the coinsurance expense		The maximum amount you can contribute to an HSA in any year you are eligible <sup>4,5</sup>	
Network			Network		Network		Network		Network			
IN <sup>6</sup>		OUT <sup>7</sup>	IN <sup>6</sup>	OUT <sup>7</sup>	IN <sup>6</sup>	OUT <sup>7</sup>	IN <sup>6</sup>	OUT <sup>7</sup>	IN <sup>6</sup>	OUT <sup>7</sup>		
<b>\$1,100</b> deductible	\$1,100	\$2,200	100%	70%	100%	70%	Not subject to deductible	100%	70%	\$1,100	\$3,450	<b>\$1,100</b>
			80%	50%	80%	50%		100%	50%	\$4,000	\$8,000	
			50%	50%	50%	50%		100%	50%	\$4,000	\$8,000	
<b>\$2,000</b> deductible	\$2,000	\$4,000	100%	70%	100%	70%	Not subject to deductible	100%	70%	\$2,000	\$5,250	<b>\$2,000</b>
			80%	50%	80%	50%		100%	50%	\$4,000	\$8,000	
			50%	50%	50%	50%		100%	50%	\$4,000	\$8,000	
<b>\$2,700</b> deductible	\$2,700	\$5,400	100%	70%	100%	70%	Not subject to deductible	100%	70%	\$2,700	\$6,650	<b>\$2,700</b>
			80%	50%	80%	50%		100%	50%	\$5,000	\$10,000	
			50%	50%	50%	50%		100%	50%	\$5,000	\$10,000	
<b>\$5,000</b> deductible	\$5,000	\$10,000	100%	70%	100%	70%		100%	70%	\$5,000	\$11,250	<b>\$2,850</b>
Network			Network		Network		Network		Network			
IN <sup>6</sup>		OUT <sup>7</sup>	IN <sup>6</sup>	OUT <sup>7</sup>	IN <sup>6</sup>	OUT <sup>7</sup>	IN <sup>6</sup>	OUT <sup>7</sup>	IN <sup>6</sup>	OUT <sup>7</sup>		
<b>\$2,200</b> deductible	\$2,200	\$4,400	100%	70%	100%	70%	Not subject to deductible	100%	70%	\$2,200	\$6,900	<b>\$2,200</b>
			80%	50%	80%	50%		100%	50%	\$7,000	\$14,000	
			50%	50%	50%	50%		100%	50%	\$7,000	\$14,000	
<b>\$4,000</b> deductible	\$4,000	\$8,000	100%	70%	100%	70%	Not subject to deductible	100%	70%	\$4,000	\$10,500	<b>\$4,000</b>
			80%	50%	80%	50%		100%	50%	\$7,000	\$14,000	
			50%	50%	50%	50%		100%	50%	\$7,000	\$14,000	
<b>\$5,450</b> deductible	\$5,450	\$10,900	100%	70%	100%	70%	Not subject to deductible	100%	70%	\$5,450	\$13,400	<b>\$5,450</b>
			80%	50%	80%	50%		100%	50%	\$10,000	\$20,000	
			50%	50%	50%	50%		100%	50%	\$10,000	\$22,500	
<b>\$10,000</b> deductible	\$10,000	\$20,000	100%	70%	100%	70%		100%	70%	\$10,000	\$22,500	<b>\$5,650</b>

# Blue OPTIONS HSA<sup>SM</sup>

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:** Federal guidelines and interpretations are subject to change.

- 1 Deductible and out-of-pocket maximum amounts are subject to change year to year in order to comply with IRS requirements.
- 2 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.
- 3 The deductible is waived for certain preventative care services received from an in-network provider.
- 4 These amounts will be updated annually for inflation. For the most up-to-date information visit [www.irs.gov](http://www.irs.gov).
- 5 Amount is limited to the high-deductible health plan's annual deductible or the amount established by the IRS for each year for single or family coverage, whichever is less. Anyone age 55 or older can contribute an additional \$800 to their HSA in 2007.
- 6 All services are limited to the allowed amount. BCBSNC allowed amount is the amount that BCBSNC determines is reasonable for covered services provided to a member, which may be established in accordance with an agreement between the provider and BCBSNC. If you use an in-network provider you will only be responsible for your deductible and any coinsurance amounts.
- 7 NOTICE: Your actual expenses for covered services may exceed the stated amount because actual provider charges may not be used to determine the payment obligations of BCBSNC or its members.
- 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 Options HSA coverage begins. You may receive credit toward the 12-month waiting period if we receive your completed Blue Options HSA application within 63 days of the termination of your previous health coverage.

Policy Number: BOptions HSA (Indiv.), 7/06  
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## LIMITATIONS & EXCLUSIONS

Like most health care plans, Blue Options HSA 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
- 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, or as specifically covered by your health benefit plan
- 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 the 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

