

BlueAdvantage		
Benefit type/description	Plan A: In-network coverage ¹	Plan B: In-network coverage ¹
Office visits Primary doctors and specialists, including surgery, lab work, therapy and radiology performed by the same doctor on the same office visit.	You pay: ¹ \$15 copayment for primary physicians, ² \$30 copayment for specialists	You pay: ¹ \$25 copayment for primary physicians, ² \$50 copayment for specialists
Preventive care Routine physical exams, including gynecological exam, well-child and well-baby care, including periodic assessments and immunizations.	You pay: ^{1,3} \$0	You pay: ^{1,3} \$0
Prescription drugs No annual limit for generic drugs. A \$2,000 maximum for brand-name drugs per person, per benefit period, then you pay 50% coinsurance.	You pay: ⁴ \$10 copayment for generics, \$45 or \$65 for brand-name, 25% coinsurance for specialty brand	You pay: ⁴ After \$200 deductible per member, \$10 copayment for generics, \$45 or \$65 for brand-name, 25% coinsurance for specialty brand
Deductible The amount you pay during the benefit period for some services before BCBSNC pays its portion. Benefits vary depending on the deductible selected.	Deductible options: \$1,000 or \$2,500	Deductible options: \$1,000, \$2,500, \$3,500 or \$5,000
Coinsurance The percentage of covered medical expenses that you pay after you've paid your deductible.	You pay: After deductible, 20%	You pay: After deductible, 30%
Coinsurance maximum The total amount of coinsurance you're required to pay for covered services in a benefit period. Once you reach the coinsurance maximum, you will not have to pay any more for coinsurance for covered medical expenses for the remainder of the benefit period.	Individual: \$2,000 Family: \$4,000	Individual: \$3,000 Family: \$6,000
Out-of-pocket expenses The total amount of money you pay out of pocket for covered services in a benefit period.	You pay: Deductible(s), coinsurance (up to the maximum) and copayment(s)	You pay: Deductible(s), coinsurance (up to the maximum) and copayment(s)
Lifetime maximum The maximum amount BCBSNC will pay per member for covered services.	Unlimited	Unlimited
Hospital Inpatient and outpatient facility services, drugs, blood, supplies, medical care, surgical care, therapy services, diagnostic tests, X-rays and lab work.	Inpatient & outpatient, you pay: Coinsurance after benefit period deductible	Inpatient & outpatient, you pay: Coinsurance after benefit period deductible
Urgent care centers Provide services for a sudden or unexpected condition requiring prompt diagnosis or treatment to prevent chronic illness, prolonged impairment or a more hazardous treatment. Examples: sprains, some lacerations and dizziness.	You pay: \$30 copayment	You pay: \$50 copayment
Emergency room services Services for the sudden onset of a condition that a person could reasonably expect the absence of immediate medical attention to result in placing one's health at risk.	You pay: \$150 copayment ⁵	You pay: \$150 copayment ⁵
Ambulatory surgery centers A licensed or certified non-hospital 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.	You pay: Coinsurance after benefit period deductible	You pay: Coinsurance after benefit period deductible
Mental health and substance abuse Inpatient and outpatient professionals. Includes 10 office visits (or) outpatient visits and five inpatient day limits.	You pay: 50% after deductible	You pay: 50% after deductible
Vision Routine eye exam.	You pay: \$15 copayment	You pay: \$25 copayment
Other Services* Durable medical equipment, home health care, home infusion therapy, hospice care, private duty nursing, ambulance services, skilled nursing facilities (to 60 days per year) and dental accident.	You pay: Coinsurance after benefit period deductible	You pay: Coinsurance after benefit period deductible
Maternity rider** Pre- and post-natal coverage.	Rider available. You pay coinsurance after benefit period deductible.	Rider available. You pay coinsurance after benefit period deductible.

* High-tech diagnostic imaging scans, such as CT scans, MRIs, MRAs and PET scans, are subject to deductible and coinsurance payments regardless of where service is provided.

** Excludes child dependents.



BlueAdvantage		
Benefit type/description	Plan C: In-network coverage ¹	Out-of-network coverage ¹
Office visits Primary doctors and specialists, including surgery, lab work, therapy and radiology performed by the same doctor on the same office visit.	You pay: ¹ \$30 copayment for primary physicians, ² \$60 copayment for specialists	You pay: ¹ 30% after benefit period deductible
Preventive care Routine physical exams, including gynecological exam, well-child and well-baby care, including periodic assessments and immunizations.	You pay: ^{1,3} \$0	You pay: ^{1,3} 30% after benefit period deductible
Prescription drugs No annual limit for generic drugs. A \$2,000 maximum for brand-name drugs per person, per benefit period, then you pay 50% coinsurance.	You pay: ⁴ After \$500 deductible per member, \$10 copayment for generics, \$45 or \$65 for brand-name 25% coinsurance for specialty brand	Same as in network, plus the charges exceeding the allowed amount
Deductible The amount you pay during the benefit period for some services before BCBSNC pays its portion. Benefits vary depending on the deductible selected.	Deductible options: \$3,500 or \$5,000	Same as in network
Coinsurance The percentage of covered medical expenses that you pay after you've paid your deductible.	You pay: After deductible, 50%	You pay: After deductible, Plan A 30% , Plan B 40% , Plan C 60%
Coinsurance maximum The total amount of coinsurance you're required to pay for covered services in a benefit period. Once you reach the coinsurance maximum, you will not have to pay any more for coinsurance for covered medical expenses for the remainder of the benefit period.	Individual: \$3,000 Family: \$6,000	When using out-of-network providers, your coinsurance maximum is higher than the in-network coinsurance maximum. Maximums vary based on plan selected.
Out-of-pocket expenses The total amount of money you pay out of pocket for covered services in a benefit period.	You pay: Deductible(s), coinsurance (up to the maximum) and copayment(s)	You pay: Deductible(s), coinsurance (up to the maximum), copayment(s), and amounts over the allowed amount.
Lifetime maximum The maximum amount BCBSNC will pay per member for covered services.	Unlimited	Same as in network
Hospital Inpatient and outpatient facility services, drugs, blood, supplies, medical care, surgical care, therapy services, diagnostic tests, X-rays and lab work.	Inpatient & outpatient, you pay: Coinsurance after benefit period deductible	Inpatient & outpatient, you pay: Coinsurance after benefit period deductible
Urgent care centers Provide services for a sudden or unexpected condition requiring prompt diagnosis or treatment to prevent chronic illness, prolonged impairment or a more hazardous treatment. Examples: sprains, some lacerations and dizziness.	You pay: \$60 copayment	You pay: Same copayment as in network
Emergency room services Services for the sudden onset of a condition that a person could reasonably expect the absence of immediate medical attention to result in placing one's health at risk.	You pay: \$150 copayment ⁵	You pay: \$150 copayment ⁵
Ambulatory surgery centers A licensed or certified non-hospital 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.	You pay: Coinsurance after benefit period deductible	You pay: Coinsurance after benefit period deductible
Mental health and substance abuse Inpatient and outpatient professionals. Includes 10 office visits (or) outpatient visits and five inpatient day limits.	You pay: 50% after deductible	You pay: 50% after benefit period deductible (Plans A and B); 60% after benefit period deductible (Plan C)
Vision Routine eye exam.	You pay: \$30 copayment	Not available
Other Services* Durable medical equipment, home health care, home infusion therapy, hospice care, private duty nursing, ambulance services, skilled nursing facilities (to 60 days per year) and dental accident.	You pay: Coinsurance after benefit period deductible	You pay: Coinsurance after benefit period deductible
Maternity rider** Pre- and post-natal coverage.	Rider available. You pay coinsurance after benefit period deductible.	Rider available. You pay coinsurance after benefit period deductible.

* High-tech diagnostic imaging scans, such as CT scans, MRIs, MRAs and PET scans, are subject to deductible and coinsurance payments regardless of where service is provided.

** Excludes child dependents.

Limitations & Exclusions

Like most health care plans, Blue Advantage has some limitations and exclusions. You must qualify medically. If your application is approved, you will receive a Member Guide. It will contain detailed information about plan benefits, exclusions and limitations.

This is a partial list of benefits that are not payable to Blue Advantage:

- Services for or related to conception by artificial means or for reversal of sterilization
- Treatment of sexual dysfunction not related to organic disease
- Treatment or studies leading to or in connection with sex changes or modifications and related care
- Services that are investigational in nature or obsolete, including any service, drugs, procedure or treatment directly related to an investigational treatment
- Side effects and complications of noncovered services, except for emergency services in the case of an emergency
- Services that are not medically necessary
- Dental services provided in a hospital, except as specifically covered by your health benefit plan
- 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 (or after) the effective dates of coverage
- Custodial care, domiciliary care or rest cures
- Eyeglasses or contact lenses or refractive eye surgery
- Services to correct nearsightedness or refractive errors
- 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 rider 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
- For any condition suffered as a result of any act of war or while on active or reserve military duty
- Services for which a charge is not normally made in the absence of insurance, or services provided by an immediate relative
- Non-prescription drugs and prescription drugs or refills which exceed the maximum supply
- Personal hygiene, comfort and/or convenience items
- For telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, charges for obtaining medical records, and late payment charges
- 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 (BCBSNC) for fraud or intentional misrepresentation of information on your application. 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.⁶ (Pre-existing conditions apply only to adults age 19 and older and do not apply to children age 18 or younger.) The policy form number for Blue Advantage is PPO-I, 6/11. This brochure contains a summary of the 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.

Blue Advantage is not a high-deductible health plan (HDHP) under the federal tax code, and therefore is not intended to be paired with a health savings account (HSA). Benefits and premiums vary depending on plan selected.

- 1 All services are limited to the allowed amount. If you go to an out-of-network provider, 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 health benefit plan's and member's payment obligations.
- 2 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.
- 3 Preventive care services as defined by recent federal regulations are covered at 100% in-network. Coverage for certain preventive care services (such as routine physical exams, well-baby and well-child care, and immunizations) is limited to in-network benefits only. However, state-mandated preventive services are available out-of-network, for which members will pay deductible and coinsurance, plus charges over the allowed amount. Visit bcbsnc.com/preventive for more details.
- 4 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. 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. Specialty brand-name drugs require member coinsurance.
- 5 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.
- 6 Pre-existing conditions are those for which medical advice, diagnosis, care or treatment was received or recommended within the 12 months immediately preceding the date that your plan's coverage begins. You may receive credit toward the 12-month waiting period if you have not had a break in coverage of more than 63 consecutive days between your prior health plan and this health plan, and if we receive proof of such prior coverage.

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