

# Compare plan benefits

Take a look at our side-by-side comparison of benefits for our Blue Advantage and Blue Options HSA plans.

Benefit type	Benefit description	Plan A: In-network coverage <sup>15</sup>
<b>Office visits - in network</b>	Primary doctors and specialists, including surgery, lab work, therapy and radiology performed by the same doctor on the same day in office.	You pay: <sup>15</sup> <b>\$15</b> copayment for primary physicians, <sup>16</sup> <b>\$30</b> copayment for specialists
<b>Preventive care</b>	Routine physical exams, including gynecological exam; well-child and well-baby care, including periodic assessments and immunizations.	You pay: <sup>2,15</sup> <b>\$15</b> copayment for primary physicians, <sup>16</sup> <b>\$30</b> copayment for specialists
<b>Prescription drugs</b>	No annual limit for generic drugs. A \$2,000 maximum for brand-name drugs per person, per benefit period.	You pay: <sup>4</sup> <b>\$10</b> copayment for generics, <b>\$35</b> or <b>\$50</b> for brand-name, <b>25%</b> coinsurance for specialty brand
<b>Deductible</b>	The amount you pay during the benefit period for some services before BCBSNC pays its portion.	Deductible options: <b>\$250, \$500, \$1,000</b> or <b>\$2,500</b> Benefits vary depending on the deductible selected
<b>Coinsurance</b>	The percentage of covered medical expenses that you pay after you've paid your deductible.	You pay: After deductible, <b>20%, 0%</b> (0% coinsurance is not available on the \$2,500 deductible option)
<b>Coinsurance maximum</b>	The total amount of coinsurance you're required to pay for covered services in a year. 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 year.	Individual: <b>\$0</b> for <b>0%</b> coinsurance plans; <b>\$2,000</b> for <b>20%</b> for coinsurance plans; Family: <b>\$0</b> for <b>0%</b> coinsurance plans; <b>\$4,000</b> per family for <b>20%</b> for coinsurance plans
<b>Out-of-pocket expenses</b>	The total amount of money you pay out of pocket in a benefit period.	You pay: Deductible(s), coinsurance (up to the maximum) and copayment(s)
<b>Lifetime maximum</b>	The maximum amount BCBSNC will pay per member for covered services.	Unlimited
<b>Hospital</b>	Inpatient and outpatient facility services, drugs, blood, supplies, medical care, surgical care, therapy services, diagnostic tests, X-rays, lab work and well-baby care (including periodic assessments and immunizations).	Inpatient, you pay: Coinsurance after benefit period deductible
	Outpatient laboratory tests and mammograms performed alone. (May require pre-authorization.)	Outpatient, you pay: <b>0%</b> with no deductible
<b>Urgent care centers</b>	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: <b>\$30</b> copayment
<b>Emergency room services</b>	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: <b>\$150</b> copayment <sup>17</sup>
<b>Ambulatory surgery centers</b>	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
<b>Mental health and substance abuse</b>	Inpatient and outpatient professionals. A \$2,000 benefit period maximum and a \$10,000 lifetime maximum per member.	You pay: <b>50%</b> after deductible
<b>Vision</b>	Routine eye exam.	You pay: <b>\$15</b> copayment
<b>Other services</b>	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
<b>Maternity coverage</b>	Pre- and post-natal coverage.	Option available. You pay coinsurance after benefit period deductible.
<b>Child-only coverage</b>	Coverage for children 18 years of age and younger. No full-time student requirement.	Available

<sup>15</sup>**Please note:** The Blue Options HSA \$1,200 Individual and \$2,400 Family deductible options may not be available for policy purchase throughout the entire 2009 benefit period. To verify current deductible options, contact your agent.

# BlueAdvantage

## Plan B:

In-network coverage<sup>15</sup>

You pay:<sup>15</sup> **\$25** copayment for primary physicians,<sup>16</sup>  
**\$50** copayment for specialists

You pay:<sup>2,15</sup> **\$25** copayment for primary physicians,<sup>16</sup>  
**\$50** copayment for specialists

You pay:<sup>4</sup> After \$200 deductible per member,  
**\$10** copayment for generics, **\$35** or **\$50** for brand-name,  
**25%** coinsurance for specialty brand

Deductible options: **\$500, \$1,000, \$2,500, \$3,500**  
or **\$5,000**

You pay: After deductible, **30%**

Individual: **\$3,000**;  
Family: **\$6,000**

You pay: Deductible(s), coinsurance (up to the  
maximum) and copayment(s)

\$5 million

Inpatient, you pay: Coinsurance after benefit period  
deductible

Outpatient, you pay: **0%** with no deductible

You pay: **\$50** copayment

You pay: **\$150** copayment<sup>17</sup>

You pay: Coinsurance after benefit period deductible

You pay: **50%** after deductible

Not available

You pay: Coinsurance after benefit period deductible

Option available. You pay coinsurance after benefit  
period deductible.

Available

## Plan C:

In-network coverage<sup>15</sup>

You pay:<sup>15</sup> **\$30** copayment for primary physicians,<sup>16</sup>  
**\$60** copayment for specialists

You pay:<sup>2,15</sup> **\$30** copayment for primary physicians,<sup>16</sup>  
**\$60** copayment for specialists

You pay:<sup>4</sup> After \$500 deductible per member, **\$10**  
copayment for generics, **\$35** or **\$50** for brand-name  
**25%** coinsurance for specialty brand

Deductible options: **\$1,000, \$2,500, \$3,500** or **\$5,000**

You pay: After deductible, **50%**

Individual: **\$3,000**;  
Family: **\$6,000**

You pay: Deductible(s), coinsurance (up to the  
maximum) and copayment(s)

\$5 million

Inpatient, you pay: Coinsurance after benefit period  
deductible

Outpatient, you pay: **0%** with no deductible

You pay: **\$60** copayment

You pay: **\$150** copayment<sup>17</sup>

You pay: Coinsurance after benefit period deductible

You pay: **50%** after deductible

Not available

You pay: Coinsurance after benefit period deductible

Option available. You pay coinsurance after benefit  
period deductible.

Available