

NORTH CAROLINA STATE UNIVERSITY

Postdoc Medical Insurance Plan

SUMMARY OF BENEFITS July 1 2008- June 30 2009

Service	In-Network	Out-of-Network
Student Health Services - medical services received at Student Health	100%, no deductible	Not applicable
Lifetime Maximum	Unlimited	Unlimited
Policy Year Deductible	\$100 Individual \$300 Family	\$200 Individual \$600 Family
Coinsurance Maximum (prescription drugs do not apply to the coinsurance maximum)	\$2,000 Individual \$6,000 Family	\$4,000 Individual \$12,000 Family
Physician Office Services	90% after deductible	70% after deductible
Office surgery, x-rays and labs	90% after deductible	70% after deductible
Gynecological Exams, Pap Smears, Screening Mammograms, Prostate Specific Antigen Tests	90% after deductible	70% after deductible
Routine Physical Exams	90% after deductible	Not Covered
Routine Vision Care (\$100 hardware allowance per policy year for glasses and contacts, not subject to deductible and coinsurance)	One vision exam per policy year covered at 90% after deductible	Not Covered
Well-Baby, Immunizations (to age 6)	90% after deductible	Not Covered
Short-term Rehabilitative Therapies (a total of 30 visits per benefit period for each of the two therapies (1) physical/occupational including chiropractic and (2) speech)	90% after deductible	70% after deductible
Maternity	90% after deductible	70% after deductible
Infertility and Sexual Dysfunction Services (limited to \$5,000 in all places of service)	90% after deductible	70% after deductible
Inpatient Hospital Services	90% after deductible	70% after deductible
Outpatient Hospital services	90% after deductible	70% after deductible
Emergency Room	90% after deductible	90% after deductible
Urgent Care	90% after deductible	90% after deductible
Ambulatory Surgical Center	90% after deductible	70% after deductible
Skilled Nursing Facility (limited to 60 days per benefit period)	90% after deductible	70% after deductible
Home Health Care (limited to 60 days per benefit period)	90% after deductible	70% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible
Ambulance	90% after deductible	70% after deductible
Hospice	90% after deductible	70% after deductible
Mental Health Office Visits (limited to 40 visits per benefit period)**	90% after deductible	70% after deductible
Inpatient and Outpatient Mental Health Services (limited to 30 days per benefit period)**	90% after deductible	70% after deductible
Substance Abuse (limited to \$8,000 per benefit period and \$16,000 lifetime)	90% after deductible	70% after deductible
Medications		
Medications received at Student Health Service	\$20 Copay per 30 day supply	Not applicable
Medications received at any retail pharmacy		
Tier 1 Medications	\$25 Copay per 30 day supply	Copay plus amount over allowed amount
Tier 2 Medications	\$35 Copay per 30 day supply	Copay plus amount over allowed amount
Tier 3 Medications	\$50 Copay per 30 day supply	Copay plus amount over allowed amount
Tier 4 Medications	25% of cost with a minimum of \$50 and a maximum of \$100	Copay plus amount over allowed amount

**Inpatient Services need to be pre-certified.*

**Please note that the above is only a brief summary of your coverage. Please refer to your Blue Cross and Blue Shield Benefits Booklet for details regarding your plan.*

***Certain mental health conditions do not have visit limits. For a list of these conditions, please refer to your benefit booklet*