

# ADVANCE BLUE

Type of Coverage	Medically Underwritten			
Benefit Period	Contract Year			
Benefit Period Dollar Maximum	Unlimited			
Plan Details	Network		Out-of-Network	
	Advance Blue Pays	You Pay	Advance Blue Pays	You Pay
<b>Individual - 1 Member Per Agreement</b>				
Deductible – Individual		\$1,200, \$2,600 or \$3,500 deductible is combined in and out-of-network		\$1,200, \$2,600 or \$3,500 deductible is combined in and out-of-network
Out-of-Pocket Limit – Individual The amount of deductible and copayments paid do not count toward the out-of-pocket limit		\$1,000, \$1,200, \$1,500 Separate out-of-pocket limits apply to in and out-of-network benefits		\$2,000, \$2,400, \$3,000 Separate out-of-pocket limits apply to in and out-of-network benefits
<b>Family - 2 or more Family Members Per Agreement</b>				
Deductible – Family <sup>1</sup>		\$2,400, \$5,200 or \$7,000 deductible is combined in and out-of-network		\$2,400, \$5,200 or \$7,000 deductible is combined in and out-of-network
Out-of-Pocket Limit - Family The amount of deductible and copayments paid do not count toward the out-of-pocket limit		\$2,000, \$2,400, \$3,000 Separate out-of-pocket limits apply to in and out-of-network benefits		\$4,000, \$4,800, \$6,000 Separate out-of-pocket limits apply to in and out-of-network benefits
<b>Coinsurance - Individual or Family</b>				
Coinsurance – Paid only after deductibles shown have been paid	90%	10%	70%	30%
<b>Plan Services</b>				
Preventive Care <sup>2</sup> - Annual deductible and coinsurance <b>do not apply</b> to the Preventive Care services listed below.				
Routine Annual Physical Exam	100%	0%	Pediatric - 70% Adult Not Covered	Pediatric - 30% Adult - 100%
Routine Annual Gynecological Exam	100%	0%	Not Covered	100%
Immunizations Adult and Pediatric	100%	0%	Not Covered	100%
Mammographic Screenings	100%	0%	Not Covered	100%
Preventive Medications <sup>3</sup>	100%	0%	Not Covered	100%
<b>Illness or Injury Care</b>				
Primary Care Office Visit	100% after copayment	\$20 copayment (does not apply toward deductible and out-of-pocket limit)	70%	30%
Specialist Office Visit	100% after copayment	\$30 copayment (does not apply toward deductible and out-of-pocket limit)	70%	30%
Emergency Room Visit	90%	10%	90%	10%
Urgent Care/Clinic Visit	90%	10%	70%	30%
Prescription Drugs	100% after copayment	Retail: 31/60/90 day supply \$8/\$16/\$24 generic \$40/\$80/\$120 brand	Not Covered	100%
Maternity Services	90%	10%	70%	30%
Ambulance Service	90%	10%	70%	30%
Inpatient Hospital Services	90%	10%	70% during 90-day benefit period	30% during 90-day benefit period. 100% after 90-day benefit period
Medical/Surgical Expenses	90%	10%	70%	30%
Diagnostic Services <sup>4</sup> (Lab, X-ray and other services)	Basic Diagnostics: 100% after copayment Advanced Diagnostics: 90%	Basic Diagnostics: \$20 copayment (does not apply toward deductible and out-of-pocket limit) Advanced Diagnostics: 10%	70%	30%
Therapy and Rehabilitation Services <sup>5</sup>	90%	10%	70%	30%
Spinal Manipulations <sup>5</sup>	90%	10%	70%	30%
Home Health Care	90%	10%	70%	30%
Skilled Nursing Facility Care	90%	10%	70%	30%
Mental Health Service	Not Covered	100%	Not Covered	100%
Substance Abuse - Rehabilitation	Not Covered	100%	Not Covered	100%
Substance Abuse - Detoxification	Not Covered	100%	Not Covered	100%
Routine Eye Exam (Every 24 Months)	100%	0%	Not Covered	100%

See inside for Important Benefit Details (footnotes 1–6) at bottom of previous page. Please see Advance Blue Outline of Coverage for complete listing of benefits, exclusions and limitations.