

ADVANCE BLUE OPTIONS

Understanding Your Options

When buying health insurance coverage for you or your family, it's helpful to have options that give you the coverage that best fits your needs at a manageable monthly cost. On the following pages you'll find information on everything from monthly payments to plan benefits. If you have questions about health insurance in general, or insurance terms used to describe the plan, be sure to refer to the *Finding the Right Plan* guide in your packet.

What is Highmark Advance BlueSM?

Advance Blue Individual Comprehensive Major Medical Non-Gatekeeper Preferred-Provider Agreement is right for people who are in good health and want the safety of coverage for unexpected medical situations. It's designed to give you the protection you need and still keep your monthly costs low.

Key Features:

- Low copayments on office visits, certain diagnostic services and prescriptions
- Deductible options that help keep monthly rates lower
- Preventive care with no extra cost to you
- Vision benefit

CHOOSING YOUR ADVANCE BLUE PLAN

Your first step should be to review both the benefit and monthly rate information in this packet. If *Advance Blue* is the option that best meets your needs, your next step is to complete the enrollment application.

Advance Blue is a medically underwritten plan. This means your rate and eligibility for the plan are based on a review of your answers to the medical questions found on the application. You should know that family members, age 19 or older, are subject to a pre-existing condition limitation. Therefore, you will not receive benefits related to a pre-existing condition during the 12-month period following the date your coverage begins. This applies only for those conditions for which medical advice or treatment was recommended by or received from a physician within a five-year period prior to the date your coverage begins.

It's possible that, because of your medical history, you may not qualify for coverage at the rate indicated on the rate chart. However, you may still be eligible for coverage at one of Highmark's higher rates according to medical criteria ("underwriting guidelines"). We will notify you if you are eligible for coverage and at which rate. If you or a family member — age 19 or older — is not qualified for *Advance Blue*, we will be happy to provide you with information about our other available options.

Rates are based on your gender, age, health status, number of family members and the deductible you choose. Family rates are based on the age of the oldest family member — who is the contract holder. When the contract holder's age moves to the next age bracket, the premium will increase the month after the contract holder's birthday. For example, if the contract holder turns 35 in January, the monthly premium will increase in February from the "30–34" to the "35–39" age category.

INDIVIDUAL RATES

Male: Female:

Individual Annual Deductibles						
Age	\$1,200 Deductible		\$2,600 Deductible		\$3,500 Deductible	
<19	\$70.20	\$70.20	\$61.95	\$61.95	\$57.80	\$57.80
19-24	\$70.20	\$111.20	\$61.95	\$97.00	\$57.80	\$89.90
25-29	\$73.50	\$139.40	\$64.75	\$121.15	\$60.40	\$111.95
30-34	\$84.65	\$169.90	\$74.30	\$147.20	\$69.10	\$135.85
35-39	\$101.20	\$169.95	\$88.45	\$147.25	\$82.05	\$135.90
40-44	\$121.95	\$172.80	\$106.20	\$149.70	\$98.30	\$138.10
45-49	\$153.60	\$192.90	\$133.25	\$166.90	\$123.05	\$153.85
50-54	\$198.25	\$227.55	\$171.50	\$196.55	\$158.05	\$181.00
55-59	\$262.15	\$260.85	\$226.10	\$225.00	\$208.05	\$207.00
60-64	\$355.20	\$307.15	\$305.65	\$264.60	\$280.85	\$243.25

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FAMILY RATES

Male: Female:

Age	Parent/ Child	Parent/ Children	Husband/ Wife	Husband/Wife/ Child	Husband/Wife/ Children
\$2,400 Family Annual Deductible					
<19	\$129.85	\$129.85	\$210.05	\$210.05	\$181.40
19-24	\$129.85	\$170.85	\$210.05	\$251.05	\$181.40
25-29	\$133.15	\$199.05	\$213.35	\$279.25	\$212.90
30-34	\$144.30	\$229.55	\$224.50	\$309.75	\$254.55
35-39	\$160.85	\$229.60	\$241.05	\$309.80	\$271.15
40-44	\$181.60	\$232.45	\$261.80	\$312.65	\$294.75
45-49	\$213.25	\$252.55	\$293.45	\$332.75	\$346.50
50-54	\$257.95	\$287.25	\$338.10	\$367.40	\$425.80
55-59	\$321.80	\$320.50	\$402.00	\$400.70	\$523.00
60-64	\$414.85	\$366.80	\$495.05	\$447.00	\$662.35
\$5,200 Family Annual Deductible					
<19	\$114.30	\$114.30	\$184.25	\$184.25	\$158.95
19-24	\$114.30	\$149.35	\$184.25	\$219.30	\$158.95
25-29	\$117.10	\$173.45	\$187.05	\$243.45	\$185.90
30-34	\$126.65	\$199.55	\$196.60	\$269.55	\$221.50
35-39	\$140.80	\$199.60	\$210.75	\$269.55	\$235.70
40-44	\$158.55	\$202.05	\$228.50	\$272.00	\$255.90
45-49	\$185.60	\$219.20	\$255.55	\$289.20	\$300.15
50-54	\$223.80	\$248.90	\$293.80	\$318.85	\$368.05
55-59	\$278.45	\$277.35	\$348.40	\$347.30	\$451.10
60-64	\$358.00	\$316.95	\$428.00	\$386.90	\$570.25
\$7,000 Family Annual Deductible					
<19	\$106.50	\$106.50	\$171.35	\$171.35	\$147.70
19-24	\$106.50	\$138.55	\$171.35	\$203.40	\$147.70
25-29	\$109.05	\$160.65	\$173.90	\$225.50	\$172.35
30-34	\$117.80	\$184.55	\$182.65	\$249.35	\$204.95
35-39	\$130.75	\$184.55	\$195.60	\$249.40	\$217.95
40-44	\$147.00	\$186.80	\$211.80	\$251.65	\$236.40
45-49	\$171.75	\$202.50	\$236.60	\$267.35	\$276.90
50-54	\$206.75	\$229.65	\$271.55	\$294.50	\$339.05
55-59	\$256.70	\$255.70	\$321.55	\$320.55	\$415.05
60-64	\$329.55	\$291.95	\$394.35	\$356.75	\$524.10

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Important Benefit Details

- Advance Blue Family Deductible: For an Agreement covering more than one (1) family member, the ENTIRE family deductible must be met (within a benefit period) before Highmark will pay for covered services for ANY family member. The family deductible can be satisfied by an individual family member or a combination of one or more family members.
- The Highmark Preventive Service Schedule lists items/services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended. It is reviewed and updated periodically based on the advice of the U.S. Preventive Services Task Force, the laws and regulations of the Commonwealth of Pennsylvania and updates to clinical guidelines established by national medical organizations. Accordingly, the content of the Schedule is subject to change.
- Certain limited prescriptions and over-the-counter drugs prescribed for preventive purposes.
- Basic Diagnostic Services include four types of service: Standard Imaging Services, Laboratory and Pathology, Diagnostic Medical and Allergy Testing. Basic Diagnostic Services require a \$20 copayment per type of service, even when performed during the same visit. Advanced Diagnostic Services include but are not limited to CAT Scan, CTA, MRI, MRA, PET Scan and PET/CT Scan.
- Therapy visit limits include in and out-of-network visits. Physical medicine is limited to 15 visits per contract year. Speech therapy and occupational therapy are a combined 15 visit limit per contract year.
- Spinal manipulations are limited to 10 services per contract year in and out-of-network.

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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
Individual - 1 Member Per Agreement				
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
Family - 2 or more Family Members Per Agreement				
Deductible – Family ¹		\$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
Coinsurance - Individual or Family				
Coinsurance – Paid only after deductibles shown have been paid	90%	10%	70%	30%
Plan Services				
Preventive Care ² - Annual deductible and coinsurance do not apply 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 ³	100%	0%	Not Covered	100%
Illness or Injury Care				
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 ⁴ (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 ⁵	90%	10%	70%	30%
Spinal Manipulations ⁵	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.