BENEFITS COMPARISON

WITH THE NEW ADVANCE BLUE PRODUCT

ALL COINSURANCE AMOUNTS REPRESENT THE MEMBER'S RESPONSIBILITY **AFTER THE DEDUCTIBLE IS MET.**

	PPO BLUE HDHP		ADVANCE BLUE PPO		DIRECT BLUE PPO	
	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK
HSA Compatible[1]	Yes		No		No	
Individual Deductible	$1,200/$2,600/$3,500	Choice of network deductible applies to out-of-network benefits	$1,200/$2,600/$3,500 Medical Only	Choice of network deductible applies to out-of-network benefits	$250/$500	$500
Family Deductible	$2,400/$5,200/$7,000[2]	Choice of network deductible applies to out-of-network benefits	$2,400/$5,200/$7,000[2] Medical Only	Choice of network deductible applies to out-of-network benefits	$750/$1,500[3]	$500/$1,500[3]
Individual Out-of-Pocket Limit[4]	$1,000/$1,200/$1,500	$2,000/$2,400/$3,000	$1,000/$1,200/$1,500	$2,000/$2,400/$3,000	$1,500	
Family Out-of-Pocket Limit[4]	$2,000/$2,400/$3,000	$4,000/$4,800/$6,000	$2,000/$2,400/$3,000	$4,000/$4,800/$6,000	$4,500	
Coinsurance	90%	70%	90%	70%	90%	70%
Benefit Period and Lifetime Limits	Unlimited					
Preventive Care Adult Care Immunizations Mammogram Pediatric Care Immunizations	100%; exempt from deductible	Not covered, except for Pediatric Care at 70%	100%; exempt from deductible	Not covered, except for Pediatric Care at 70%	100%; exempt from deductible	Not covered, except for Pediatric Care at 70%
Office Visits	90%	70%	$20 PCP; $30 Specialist, deductible and coinsurance do not apply	70%	90%	70%
Emergency Care	90%		90%		90% after $40 copayment (waived if admitted)	
Basic Diagnostic Services[5]	90%	70%	$20 copayment, deductible and coinsurance do not apply	70%	90%	70%

CONTINUED

BENEFITS COMPARISON CONTINUED

WITH THE NEW ADVANCE BLUE PRODUCT

ALL COINSURANCE AMOUNTS REPRESENT THE MEMBER'S RESPONSIBILITY **AFTER THE DEDUCTIBLE IS MET.**

	PPO BLUE HDHP		ADVANCE BLUE PPO		DIRECT BLUE PPO	
	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK
Advanced Diagnostic Services[6] Inpatient/Outpatient Services[7] Maternity and Newborn Care Outpatient Rehabilitation and Therapy Services[8] Spinal Manipulation[9]	90%	70%	90%	70%	90%	70%
Prescription Drugs	You pay prescription discounted cost and are reimbursed 90% after you meet your deductible; then 100% after you meet your out-of-pocket limit.	Not covered	$8 generic; $40 brand name drugs, then 100%; closed formulary; mandatory hard generic; deductible and coinsurance do not apply	Not covered	$100 deductible[10]/ per calendar year; then 100%; $10 generic, $20 brand; closed formulary, hard mandatory generic	Not covered
Preventive Medications[11]	100%; exempt from deductible	Not covered	100%; exempt from deductible	Not covered	100%; exempt from deductible	Not covered
Eye Examinations and Refractions	Not covered; Effective 10/1/11, 100%; one exam every 24 months; exempt from deductible; services must be provided by a participating vision provider		100%; one exam every 24 months; exempt from deductible; services must be provided by a participating vision provider	Not covered	100%; one exam every 24 months; exempt from deductible; services must be provided by a participating vision provider	Not covered

CONTINUED

1. Health Savings Account (HSA) – A savings account used to pay current qualified medical expenses, as well as to save for future qualified medical expenses on a tax-advantaged basis.
2. One or more family members must satisfy the ENTIRE family deductible before the insurance company will pay for covered services for any family member.
3. If your Agreement covers more than one family member, each covered individual must meet his/her individual deductible (within a contract year) before the insurance company will pay for covered services for that individual. No individual member may satisfy the entire family deductible. After three individual family members have satisfied their deductibles, the deductible for all remaining family members will also be considered satisfied.
4. Out-of-pocket limit does not include deductibles or copayments, where applicable.
5. Basic diagnostics include standard imaging services, laboratory and pathology, diagnostic medical, and allergy testing.
6. Advanced diagnostic services include CT, CTA, MRI, MRA, PET Scan and PET/CT Scan. All products require pre-authorization through National Imaging Associates.
7. Inpatient/Outpatient Services – Out-of-network limit of 90 days per benefit period for all products on this grid.
8. Outpatient Therapies – Limit of 15 combined visits for physical medicine and occupation/speech therapy per contract year for PPO Blue and Advance Blue; per calendar year for Direct Blue.
9. Spinal Manipulation – Limit of 10 visits per contract year for PPO Blue and Advance Blue; per calendar year for Direct Blue.
10. For Direct Blue, the prescription drug deductible requires each covered individual to meet his/her drug deductible (within a calendar year) before the insurance company will pay for covered medications for that individual.
11. Certain limited prescription and over-the-counter drugs prescribed for preventive purpose, based on a predefined schedule.

CS 103653