DIRECT 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.

What is Highmark Direct Blue®?

Individuals and families choose *Direct Blue Comprehensive Major Medical Preferred-Provider Subscription Agreement for Individual Members, Utilizing the Premier Blue℠ Shield Professional Provider Network and the Highmark Blue Shield Facility Provider Network, Without a Gatekeeper* for its comprehensive health care protection, the assurance of predictable costs and a choice of lower-deductible options to fit your budget.

Key Features:

- Low-deductible options
- Prescription drug coverage
- Comprehensive coverage
- Preventive care with no extra cost to you

CHOOSING YOUR DIRECT BLUE PLAN

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

Direct 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 *Direct 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: (white) **Female:** (blue)

Individual Annual Deductibles				
Age	$250 Deductible		$500 Deductible	
	Male	Female	Male	Female
<19	$136.15	$136.15	$131.45	$131.45
19-24	$136.15	$223.25	$131.45	$215.20
25-29	$143.10	$283.30	$138.10	$272.90
30-34	$166.80	$348.15	$160.95	$335.25
35-39	$202.00	$348.20	$194.75	$335.35
40-44	$246.10	$354.25	$237.20	$341.20
45-49	$313.45	$397.05	$301.90	$382.25
50-54	$408.50	$470.75	$393.20	$453.10
55-59	$544.30	$541.50	$523.80	$521.15
60-64	$742.10	$639.95	$721.35	$619.20

Effective since November 1, 2010

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FAMILY RATES

Male: (white) **Female:** (blue)

Age	Parent/ Child		Parent/ Children		Husband/ Wife		Husband/Wife/ Child		Husband/Wife/ Children	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
$750 Family Annual Deductible										
<19	$253.85	$253.85	$414.95	$414.95	$359.40	$359.40	$476.30	$476.30	$637.15	$637.15
19-24	$253.85	$341.00	$414.95	$502.10	$359.40	$359.40	$476.30	$476.30	$637.15	$637.15
25-29	$260.80	$401.00	$421.90	$562.10	$426.40	$426.40	$543.30	$543.30	$704.10	$704.10
30-34	$284.55	$465.90	$445.65	$627.00	$514.95	$514.95	$631.85	$631.85	$792.70	$792.70
35-39	$319.75	$465.95	$480.85	$627.10	$550.20	$550.20	$667.15	$667.15	$828.00	$828.00
40-44	$363.90	$472.05	$525.00	$633.15	$600.35	$600.35	$717.35	$717.35	$878.20	$878.20
45-49	$431.15	$514.75	$592.25	$675.85	$710.50	$710.50	$827.40	$827.40	$988.20	$988.20
50-54	$526.20	$588.50	$687.30	$749.60	$879.25	$879.25	$996.15	$996.15	$1,157.00	$1,157.00
55-59	$662.00	$659.25	$823.10	$820.35	$1,085.80	$1,085.80	$1,202.75	$1,202.75	$1,363.55	$1,363.55
60-64	$859.85	$757.70	$1,020.95	$918.80	$1,382.05	$1,382.05	$1,499.00	$1,499.00	$1,659.85	$1,659.85
$1,500 Family Annual Deductible										
<19	$245.05	$245.05	$400.30	$400.30	$346.65	$346.65	$459.45	$459.45	$614.40	$614.40
19-24	$245.05	$328.80	$400.30	$484.10	$346.65	$346.65	$459.45	$459.45	$614.40	$614.40
25-29	$251.70	$386.45	$407.00	$541.75	$411.00	$411.00	$523.80	$523.80	$678.85	$678.85
30-34	$274.55	$448.85	$429.85	$604.15	$496.20	$496.20	$609.00	$609.00	$764.00	$764.00
35-39	$308.35	$448.95	$463.65	$604.20	$530.10	$530.10	$642.90	$642.90	$797.95	$797.95
40-44	$350.75	$454.75	$506.05	$610.05	$578.40	$578.40	$691.15	$691.15	$846.20	$846.20
45-49	$415.50	$495.85	$570.80	$651.15	$684.15	$684.15	$796.90	$796.90	$951.95	$951.95
50-54	$506.80	$566.70	$662.10	$722.00	$846.30	$846.30	$959.20	$959.20	$1,114.15	$1,114.15
55-59	$637.40	$634.75	$792.70	$790.05	$1,044.95	$1,044.95	$1,157.80	$1,157.80	$1,312.80	$1,312.80
60-64	$827.65	$729.40	$982.95	$884.70	$1,340.55	$1,340.55	$1,442.60	$1,442.60	$1,597.65	$1,597.65

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Important Benefit Details

[1] You are responsible for out-of-pocket costs each Benefit Period up to a maximum amount of $1,500 for individuals and $4,500 for family. Thereafter, the Plan pays 100% of the Provider's Allowable Charge during the remainder of the Benefit Period. This amount does not include Prescription Drugs, Private Duty Nursing Services, amounts paid for Copayments or Deductibles, or amounts in excess of the Provider's Allowable Charge.
[2] Direct Blue Family Deductible: For an Agreement covering more than one (1) family member, each covered individual must meet his/her individual deductible (within a Benefit Period) before Highmark will pay for covered services for that individual. No individual member may satisfy the entire family deductible. Only after three (3) individual family members have satisfied their deductibles will the deductibles for all remaining family members also be considered to have been satisfied.
[3] 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.
[4] Certain limited prescriptions and over-the-counter drugs prescribed for preventive purposes.
[5] Therapy visit limits include in and out-of-network visits. Physical medicine is limited to 15 visits per calendar year. Speech therapy and occupational therapy are a combined 15 visit limit per calendar year.
[6] Spinal manipulations are limited to 10 services per calendar year combined in and out-of-network.

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DIRECT BLUE

Type of Coverage	Medically Underwritten			
Benefit Period	Contract Year			
Benefit Period Dollar Maximum	Unlimited			
Plan Details	Network		Out-of-Network	
	Direct Blue Pays	You Pay[1]	*Direct Blue* Pays	You Pay[1]
Individual - 1 Member Per Agreement				
Deductible - Individual		$250 or $500 Separate deductibles apply to in and out-of-network benefits		$500 Separate deductibles apply to in and out-of-network benefits
Out-of-Pocket Limit - Individual The amount of deductible and copayments paid do not count toward the out-of-pocket limit		$1,500 out-of-pocket limit combined in and out-of-network		$1,500 out-of-pocket limit combined in and out-of-network
Family - 2 or more Family Members Per Agreement				
Deductible - Family[2]		$250 per person with $750 maximum or $500 per person with $1,500 maximum. Separate deductibles apply to in and out-of-network benefits		$1,500 Separate deductibles apply to in and out-of-network benefits
Out-of-Pocket Limit - Family The amount of deductible and copayments paid do not count toward the out-of-pocket limit		$4,500 out-of-pocket limit combined in and out-of-network		$4,500 out-of-pocket limit combined in and out-of-network
Coinsurance - Individual or Family				
Coinsurance - Paid only after deductibles shown have been paid	90%	10%	70%	30%
Plan Services				
Preventive Care[3] - 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[4]	100%	0%	Not Covered	100%
Illness or Injury Care				
Primary Care Office Visit	90%	10%	70%	30%
Specialist Office Visit	90%	10%	70%	30%
Emergency Room Visit	90% after copayment	10% after $40 copayment per visit. Copayment waived if admitted as inpatient	90% after copayment	10% after $40 copayment per visit. Copayment waived if admitted as inpatient
Urgent Care/Clinic Visit	90%	10%	70%	30%
Prescription Drugs	100 % after annual deductible and copayment	$100 annual deductible per person, then copayments of $10/generic and $20/brand-name	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 (Lab, X-ray and other services)	90%	10%	70%	30%
Therapy and Rehabilitation Services[5]	90%	10%	70%	30%
Spinal Manipulations[6]	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 the bottom of previous page. Please see Direct Blue Outline of Coverage for complete listing of benefits, exclusions and limitations.

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