

# PREFERRED 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. On the following pages you'll find information on everything from monthly payments to plan benefits.

## What is Highmark Preferred Blue®?

*Preferred Blue Individual Comprehensive Major Medical Preferred-Provider Agreement* is right for individuals and families who want comprehensive coverage. It's designed to give you the protection you need from providers both in and out-of-network.

### Key Features:

- Pays 80% in-network
- Low deductible options
- Prescription drug coverage
- Preventive care with no extra cost to you

# CHOOSING YOUR PREFERRED BLUE PLAN

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

*Preferred Blue* is a guaranteed issue plan. This means you are not required to complete a medical questionnaire to become enrolled in the plan. You should know that, except for specific circumstances\*, 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.

Rates are based on the number of family members covered and the deductible you choose.

## INDIVIDUAL/FAMILY RATES

Individual/Family Deductibles	One Person	One Parent/Child	One Parent/Children	Husband/Wife	Two Parents/Child	Two Parents/Children
\$500/\$1,500	\$639.00	\$952.15	\$1,265.25	\$1,278.15	\$1,591.25	\$1,904.45
\$1,000/\$3,000	\$571.45	\$851.45	\$1,131.55	\$1,142.90	\$1,422.90	\$1,702.95

Effective January 1, 2012

\* If you are enrolling in Preferred Blue because you are converting from Highmark group coverage to an individual policy, there *may* be no lapse in coverage, and pre-existing condition limitations *may* be waived for you and any family member that was active on the group policy when it terminated.



HAVE QUESTIONS?

CALL 1-800-847-2004 OR VISIT HIGHMARKDIRECT.COM

# PREFERRED BLUE

Coverage Type: <b>Guaranteed Issue</b>	Benefit Period: <b>Contract Year</b>		Benefit Period Dollar Maximum: <b>Unlimited</b>	
Plan Details	Network		Out-of-Network	
	Preferred Blue Pays	You Pay	Preferred Blue Pays	You Pay
<b>Individual - 1 Member Per Agreement</b>				
<b>Deductible - Individual</b>		\$500 or \$1,000 separate deductibles apply to in and out-of-network benefits		\$1,000 or \$1,500 separate deductibles apply to in and out-of-network benefits
<b>Out-of-Pocket Limit - Individual</b> The amount of deductible and copayments (if any) paid do not count toward the out-of-pocket limit		\$2,500 or \$5,000 separate out-of-pocket limits apply to in and out-of-network benefits		\$5,000 or \$10,000 separate out-of-pocket limits apply to in and out-of-network benefits
<b>Family - 2 or more Family Members Per Agreement</b>				
<b>Deductible - Family <sup>1</sup></b>		\$1,500 or \$3,000 separate deductibles apply to in and out-of-network benefits		\$3,000 or \$4,500 separate deductibles apply to in and out-of-network benefits
<b>Out-of-Pocket Limit - Family</b> The amount of deductible and copayments (if any) paid do not count toward the out-of-pocket limit		\$7,500 or \$15,000 separate out-of-pocket limits apply to in and out-of-network benefits		\$15,000 or \$30,000 separate out-of-pocket limits apply to in and out-of-network benefits
<b>Coinsurance - Individual or Family</b>				
<b>Coinsurance - Paid only after deductibles shown have been paid</b>	80%	20%	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, except as noted.				
<b>Routine Annual Physical Exam</b>	100%	0%	Pediatric - 70% Adult Not covered	Pediatric - 30% Adult - 100%
<b>Routine Annual Gynecological Exam</b>	100%	0%	Not Covered	100%
<b>Immunizations</b> Adult and Pediatric	100%	0%	Not Covered	100%
<b>Mammographic Screenings</b>	100%	0%	Not Covered	100%
<b>Preventive Medications <sup>3</sup></b>	100%	0%	Not Covered	100%
<b>Illness or Injury Care</b>				
<b>Primary Care Office Visit</b>	80%	20%	70%	30%
<b>Specialist Office Visit/Retail Clinic Visit</b>	80%	20%	70%	30%
<b>Emergency Room Visit</b>	80% after copayment	20% after \$40 copayment per visit. Copayment waived if admitted as patient.	80% after copayment	20% after \$40 copayment per visit. Copayment waived if admitted as patient.
<b>Urgent Care Center Visit</b>	80% after copayment	20% after \$40 copayment per visit	70% after copayment	30% after \$40 copayment per visit
<b>Prescription Drugs <sup>4</sup></b>	100% after copayment	\$200 deductible per calendar year, then copayment	Not Covered	100%
<b>Maternity Services</b>	80%	20%	70%	30%
<b>Ambulance Service</b>	80%	20%	70%	30%
<b>Inpatient Hospital Services</b>	80%	20%	70%	30%
<b>Medical/Surgical Expenses</b>	80%	20%	70%	30%
<b>Diagnostic Services</b> (Lab, X-ray and other services)	80%	20%	70%	30%
<b>Therapy and Rehabilitation Services <sup>5</sup></b>	80%	30%	70%	30%
<b>Spinal Manipulations <sup>6</sup></b>	80%	20%	70%	30%
<b>Home Health Care</b>	80%	20%	70%	30%
<b>Skilled Nursing Facility Care</b>	80%	20%	70%	30%
<b>Mental Health Service</b>	Not Covered	100%	Not Covered	100%
<b>Substance Abuse - Rehabilitation</b>	Not Covered	100%	Not Covered	100%
<b>Substance Abuse - Detoxification</b>	Not Covered	100%	Not Covered	100%
<b>Routine Eye Exam (Every 24 Months)</b>	100%	0%	Not Covered	100%
<b>Dental</b>	Not Covered	100%	Not Covered	100%
<b>Hearing</b>	Not Covered	100%	Not Covered	100%

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

**Call Highmark Customer Service at 1-800-847-2004, Monday through Friday, 9:00 a.m. to 9:00 p.m. TTY users may call 1-800-862-0709.** Or stop in one of the Highmark Service Centers listed below, Monday through Friday, between 8:30 a.m. and 4:30 p.m. Additional centers, with limited hours, are located in Allegheny, Beaver, Butler, Lawrence and Westmoreland counties. Please call 1-800-816-5527 for exact locations, hours and to schedule an appointment. A Customer Service representative will be pleased to help you.

This is a brief introduction to *Preferred Blue* and is not a contract. A complete description of *Preferred Blue* benefits, as well as terms and conditions of coverage and any limitations, can be found in the Agreement you receive when you enroll. For additional information regarding *Preferred Blue* benefits or value-added services, visit our website, [www.highmarkdirect.com](http://www.highmarkdirect.com).

#### **Pittsburgh Service Center**

Penn Avenue Place  
501 Penn Avenue  
Ground Floor  
Pittsburgh, PA 15222

#### **Johnstown Service Center**

125 Market Street  
One Pasquerilla Plaza  
Johnstown, PA 15901

#### **Erie Service Center**

717 State Street  
Erie, PA 16501

#### **State College Service Center**

2040 Sandy Drive  
State College, PA 16803

#### **Highmark Direct – North Hills**

McKnight Siebert Shopping Center  
4885 McKnight Road  
Pittsburgh, PA 15237  
412-544-5400  
Hours: Monday through Saturday 10:00 a.m. to 7:00 p.m.

#### **Highmark Direct – South Hills**

Norman Centre II  
1775 North Highland Road  
Pittsburgh, PA 15241  
412-544-5267  
Hours: Monday through Saturday 10:00 a.m. to 7:00 p.m.

#### **Highmark Direct – Robinson Township**

Lafayette Plaza Shopping Center  
218 Summit Park Drive  
North Fayette, PA 15275  
412-544-4900  
Hours: Monday through Saturday 10:00 a.m. to 7:00 p.m.

#### **Highmark Direct – Monroeville**

4008 William Penn Highway  
Monroeville, PA 15146  
412-544-5420  
Hours: Monday through Saturday 10:00 a.m. to 7:00 p.m.

HAVE A GREATER  IN YOUR HEALTH.

At Highmark we want to be your partner in health care. We provide you with all you need to know to make the right choices, while simplifying the process so your health care decisions become easier. Better decisions lead to better health and could even save you money.

The health care industry is changing and Highmark will be there with you each step of the way.

#### **Important Benefit Details**

- <sup>1</sup> Preferred 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.
- <sup>2</sup> 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.
- <sup>3</sup> Certain limited prescriptions and over-the-counter drugs prescribed for preventive purposes.
- <sup>4</sup> Network – Premier 2012. Formulary - Progressive. For **Retail 31-day supply**: Formulary Generic \$8; Formulary Brand \$45; Non-Formulary Brand, Non-Formulary Generic, and Formulary Specialty \$95 (Limited to a Retail 31-day supply); Non-Formulary Specialty (Limited to a Retail 31-day supply) 25% coinsurance with \$200 maximum coinsurance. For **Retail 60-day supply**: Formulary Generic \$16; Formulary Brand \$90; Non-Formulary Brand and Non-Formulary Generic \$190. For **Retail 90-day supply**: Formulary Generic \$24; Formulary Brand \$135; Non-Formulary Brand and Non-Formulary Generic \$285. For **Mail Order 90-day supply**: Formulary Generic \$16; Formulary Brand \$90; Non-Formulary Brand, Non-Formulary Generic and Formulary Specialty \$190; Non-Formulary Specialty 25% coinsurance with \$400 maximum coinsurance.
- <sup>5</sup> 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.
- <sup>6</sup> Spinal manipulations are limited to 10 services per calendar year combined in and out-of-network.

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