

SIMPLY 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 package.

What is Highmark Simply Blue?

The *Individual Comprehensive Major Medical Non-Gatekeeper Preferred Provider Subscription Agreement Identified as Simply Blue* is right for people who want protection against the high cost of unexpected illness or injury, with a low premium. It is designed to give you coverage at an affordable rate, plus preventive services that can help keep you healthy.

Key Features:

- Affordable monthly premiums
- Pays 80% in network
- Prescription drug coverage
- Preventive care with no extra cost to you

CHOOSING YOUR SIMPLY BLUE PLAN

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

Simply 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 *Simply 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 older 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 "35-40" age category.

INDIVIDUAL RATES

Male: Female:

Individual Annual Deductibles				
Age	\$500 Deductible		\$750 Deductible	
<19	\$64.80	\$64.80	\$63.75	\$63.75
19-24	\$64.80	\$97.25	\$63.75	\$95.55
25-29	\$67.75	\$112.45	\$66.65	\$110.50
30-34	\$77.85	\$123.65	\$76.55	\$121.50
35-39	\$92.80	\$136.20	\$91.25	\$133.75
40-44	\$111.60	\$152.45	\$109.65	\$149.70
45-49	\$140.20	\$171.20	\$137.70	\$168.05
50-54	\$180.65	\$202.55	\$177.35	\$198.85
55-59	\$238.45	\$232.65	\$234.00	\$228.35
60-64	\$322.60	\$274.55	\$316.50	\$269.40

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FAMILY RATES

Male: Female:

Age	Parent/Child	Parent/Children	Husband/Wife	Husband/Wife/Child	Husband/Wife/Children					
\$1,000 Family Annual Deductible										
<19	\$119.60	\$119.60	\$193.10	\$193.10	\$162.05	\$162.05	\$183.65	\$183.65	\$256.90	\$256.90
19-24	\$119.60	\$152.05	\$193.10	\$225.55	\$162.05	\$162.05	\$216.10	\$216.10	\$289.35	\$289.35
25-29	\$122.60	\$167.30	\$196.05	\$240.75	\$180.20	\$180.20	\$234.30	\$234.30	\$307.55	\$307.55
30-34	\$132.70	\$178.50	\$206.15	\$252.00	\$201.50	\$201.50	\$255.60	\$255.60	\$328.85	\$328.85
35-39	\$147.65	\$191.05	\$221.10	\$264.50	\$229.00	\$229.00	\$283.10	\$283.10	\$356.35	\$356.35
40-44	\$166.45	\$207.30	\$239.90	\$280.75	\$264.05	\$264.05	\$318.15	\$318.15	\$391.35	\$391.35
45-49	\$195.05	\$226.00	\$268.55	\$299.50	\$311.40	\$311.40	\$365.50	\$365.50	\$438.75	\$438.75
50-54	\$235.50	\$257.40	\$308.95	\$330.85	\$383.20	\$383.20	\$437.35	\$437.35	\$510.55	\$510.55
55-59	\$293.30	\$287.50	\$366.75	\$361.00	\$471.10	\$471.10	\$525.25	\$525.25	\$598.45	\$598.45
60-64	\$377.45	\$329.40	\$450.90	\$402.85	\$597.15	\$597.15	\$651.30	\$651.30	\$724.50	\$724.50
\$1,500 Family Annual Deductible										
<19	\$117.70	\$117.70	\$189.90	\$189.90	\$159.30	\$159.30	\$180.70	\$180.70	\$252.70	\$252.70
19-24	\$117.70	\$149.50	\$189.90	\$221.70	\$159.30	\$159.30	\$212.55	\$212.55	\$284.50	\$284.50
25-29	\$120.60	\$164.45	\$192.80	\$236.65	\$177.15	\$177.15	\$230.35	\$230.35	\$302.35	\$302.35
30-34	\$130.50	\$175.45	\$202.70	\$247.65	\$198.05	\$198.05	\$251.25	\$251.25	\$323.25	\$323.25
35-39	\$145.20	\$187.70	\$217.40	\$259.90	\$225.00	\$225.00	\$278.20	\$278.20	\$350.20	\$350.20
40-44	\$163.60	\$203.65	\$235.80	\$275.85	\$259.35	\$259.35	\$312.55	\$312.55	\$384.50	\$384.50
45-49	\$191.65	\$222.00	\$263.85	\$294.20	\$305.75	\$305.75	\$359.00	\$359.00	\$430.95	\$430.95
50-54	\$231.30	\$252.75	\$303.50	\$324.95	\$376.20	\$376.20	\$429.40	\$429.40	\$501.35	\$501.35
55-59	\$287.95	\$282.30	\$360.15	\$354.50	\$462.35	\$462.35	\$515.55	\$515.55	\$587.55	\$587.55
60-64	\$370.45	\$323.35	\$442.65	\$395.55	\$585.90	\$585.90	\$639.10	\$639.10	\$711.10	\$711.10

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Important Benefit Details

- Simply Blue Family Deductible: For an Agreement covering more than one family member, the ENTIRE family deductible must be met (within a Benefit Period) before Highmark will pay for covered services of 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.
- 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 (Limited to a Retail 31-day supply) \$95; 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.
- Basic Diagnostic Services include four types of service: Standard Imaging Service, Laboratory and Pathology, Diagnostic Medical and Allergy Testing. Basic Diagnostic Services require a \$25 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.

SIMPLY BLUE

Coverage Type: Medically Underwritten	Benefit Period: Contract Year		Benefit Period Dollar Maximum: Unlimited	
Plan Details	Network		Out-of-Network	
	Simply Blue Pays	You Pay	Simply Blue Pays	You Pay
Individual - 1 Member Per Agreement				
Deductible - Individual		\$500 or \$750 separate deductibles apply to in and out-of-network benefits		\$2,000 separate deductibles apply to in and out-of-network benefits
Out-of-Pocket Limit - Individual The amount of deductible and copayments (if any) paid do not count toward the out-of-pocket limit		\$4,000 separate out-of-pocket limits apply to in and out-of-network benefits		\$5,000 separate out-of-pocket limits apply to in and out-of-network benefits
Family - 2 or more Family Members Per Agreement				
Deductible - Family ¹		\$1,000 or \$1,500 separate deductibles apply to in and out-of-network benefits		\$4,000 separate deductibles apply to in and out-of-network benefits
Out-of-Pocket Limit - Family The amount of deductible and copayments (if any) paid do not count toward the out-of-pocket limit		\$8,000 separate out-of-pocket limits apply to in and out-of-network benefits		\$10,000 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	80%	20%	60%	40%
Plan Services				
Preventive Care ² - Annual deductible and coinsurance <u>do not apply</u> to the Preventive Care services listed below, except as noted.				
Routine Annual Physical Exam	100%	0%	Pediatric - 60% after deductible Adult Not Covered	Pediatric - 40% after deductible Adult Not Covered
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	\$35 copayment	60%	40%
Specialist Office Visit/ Retail Clinic Visit	100% after copayment	\$50 copayment	60%	40%
Emergency Room Visit	100% after copayment	\$150 copayment per visit. Copayment waived if admitted as patient	100% after copayment	\$150 copayment per visit. Copayment waived if admitted as patient
Urgent Care Center Visit	100% after copayment	\$50 copayment	60%	40%
Prescription Drugs	100% after copayment	Copayment ⁴	Not Covered	100%
Maternity Services	Not Covered	100%	Not Covered	100%
Ambulance Service	80%	20%	60%	40%
Inpatient Hospital Services	80% after copayment	\$500 inpatient copayment per admission, then 20%	60% during 90 days per Benefit Period	40% Limited to 90 days per Benefit Period. 100% after 90 days per Benefit Period.
Medical/Surgical Expenses	80%	20%	60%	40%
Diagnostic Services ⁵ (Lab, X-ray and other services)	Basic Diagnostics: 100% after copayment Advanced Diagnostics: 100% after copayment	Basic Diagnostics: \$25 copayment Advanced Diagnostics: \$150 copayment	60%	40%
Therapy and Rehabilitation Services ⁶	80%	20%	60%	40%
Spinal Manipulations ⁷	100% after copayment	\$50 copayment	60%	40%
Home Health Care	80%	20%	60%	40%
Skilled Nursing Facility Care	80%	20%	60%	40%
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%
Dental	Not Covered	100%	Not Covered	100%
Hearing	Not Covered	100%	Not Covered	100%

See inside for Important Benefit Details (footnotes 1–7) at the bottom of previous page. Please see Simply Blue Outline of Coverage for complete listing of benefits, exclusions and limitations.