

BENEFITS COMPARISON

WITH THE NEW SIMPLY BLUE PRODUCT

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

	SIMPLY BLUE PPO		PPO BLUE HDHP		ADVANCE BLUE PPO		DIRECT BLUE PPO	
	NETWORK	OUT OF NETWORK	NETWORK	OUT OF NETWORK	NETWORK	OUT OF NETWORK	NETWORK	OUT OF NETWORK
HSA Compatible¹	No		Yes		No		No	
Individual Deductible	\$500/\$750	\$2,000	\$1,200/\$2,600/\$3,500 Medical and prescription drug	Choice of network deductible applies to out-of-network benefits Medical and prescription drug	\$1,200/\$2,600/\$3,500	Choice of network deductible applies to out-of-network benefits	\$250/\$500	\$500
Family Deductible	\$1,000/\$1,500 ²	\$4,000 ²	\$2,400/\$5,200/\$7,000 ² Medical and prescription drug	Choice of network deductible applies to out-of-network benefits Medical and prescription drug ²	\$2,400/\$5,200/\$7,000 ²	Choice of network deductible applies to out-of-network benefits ²	\$750/\$1,500 ³	\$500/\$1,500 ³
Individual Out-of-Pocket Limit⁴	\$4,000	\$5,000	\$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 Limit⁴	\$8,000	\$10,000	\$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	80%	60%	90%	70%	90%	70%	90%	70%
Preventive Care Adult Care Immunizations Mammogram Pediatric Care Immunizations	100%; exempt from deductible	Not covered, except for Pediatric Care at 60%	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	\$35 PCP; \$50 Specialist; deductible and coinsurance do not apply	60%	90%	70%	\$20 PCP; \$30 Specialist; deductible and coinsurance do not apply	70%	90%	70%
Emergency Care	100% after \$150 copayment (waived if admitted)		90%		90%		90% after \$40 copayment (waived if admitted)	
Basic Diagnostic Services⁵	\$25 copayment, then 100%; deductible and coinsurance do not apply	60%	90%	70%	\$20 copayment, deductible and coinsurance do not apply	70%	90%	70%

BENEFITS COMPARISON CONTINUED

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	SIMPLY BLUE PPO		PPO BLUE HDHP		ADVANCE BLUE PPO		DIRECT BLUE PPO	
	NETWORK	OUT OF NETWORK	NETWORK	OUT OF NETWORK	NETWORK	OUT OF NETWORK	NETWORK	OUT OF NETWORK
Advanced Diagnostic Services⁶	\$150 copayment, then 100%; deductible and coinsurance do not apply	60%	90%	70%	90%	70%	90%	70%
Inpatient/Outpatient Services⁷	80% after \$500 copayment; deductible does not apply	60% after deductible	90%	70%	90%	70%	90%	70%
Maternity and Newborn Care	Not covered ⁸		90%	70%	90%	70%	90%	70%
Outpatient Rehabilitation and Therapy Services⁹	80% except for physical medicine/speech therapy/occupational therapy with \$50 copayment, then 100%	60%	90%	70%	90%	70%	90%	70%
Spinal Manipulation¹⁰	\$50 copayment per visit, then 100%	60%	90%	70%	90%	70%	90%	70%
Prescription Drugs	\$8 generic; \$45 brand; \$95 non-formulary brand and generic for 31-day supply, then 100%; progressive formulary; deductible and coinsurance do not apply	Not covered	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 ¹¹ /per calendar year; then 100%; \$10 generic, \$20 brand; closed formulary, hard mandatory generic	Not covered
Preventive Medications¹²	100%; exempt from deductible	Not covered	100%; exempt from deductible	Not covered	100%; exempt from deductible	Not covered	100%; exempt from deductible	Not covered
Eye Examinations and Refractions	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	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

- 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 Simply Blue covers complications from pregnancy and newborn care for the first 31 days.
- 9 Outpatient Therapies – Limit of 15 visits for physical medicine and combined visits for occupation/speech therapy per contract year for Simply Blue, PPO Blue and Advance Blue; per calendar year for Direct Blue.
- 10 Spinal Manipulation – Limit of 10 visits per contract year for Simply Blue, PPO Blue and Advance Blue; per calendar year for Direct Blue.
- 11 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.
- 12 Certain limited prescription and over-the-counter drugs prescribed for preventive purpose, based on a predefined schedule.



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