Highmark Blue Cross Blue Shield
DirectBlue Web Site Benefit Grid
$250 Deductible – Medically Underwritten

Services	**DirectBlue: An Individual Comprehensive Major Medical Preferred-Provider Health Plan; $250 Deductible; Medically Underwritten**	
	Network	**Out-of-Network**
Benefit Period	Contract Year	Contract Year
Type of Coverage	Medically Underwritten	Medically Underwritten
Deductible-Individual	$250	$500
Deductible-Family	$250/person with a maximum of $750	$500/person with a maximum of $1,500
Out of Pocket Maximum - Individual	$1,500 for network and out-of-network covered services combined	$1,500 for network and out-of-network covered services combined
Out of Pocket Maximum – Family	$4,500 for network and out-of-network covered services combined	$4,500 for network and out-of-network covered services combined
Coinsurance (only applied after any applicable deductibles have been met)	90%	70%
Lifetime Policy Maximum	$5,000,000 Includes out-of-network payments	$300,000 Included as part of network maximum
Benefit Period Maximum	$1,000,000 Includes out-of-network payments	Included as part of network maximum
Hospital Facility Expense – Inpatient	90% Includes maternity	70% Includes maternity
Emergency Room Care	90% after $40 copayment (waived if admitted)	90% after $40 copayment (waived if admitted)
Office/Home Visits	90%	70%
Medical/Surgical Expenses (except office visits)	90%	70%
Preventive Care	Routine Physical, Mammogram, Gynecological Exam, Pap Test and Pediatric Immunizations Deductible does not apply – 90%	Not Covered
Diagnostic Services (x-ray, lab and other tests)	90%	70%
Physical Medicine	90% 15 visits per calendar year	70% Included as part of network visits
Occupational and Speech Therapy	90% Combined 15 visits per calendar year	70% Included as part of network visits
Spinal Manipulations	90% 10 visits per calendar year	70% Included as part of network visits
Mental Health Service	Not Covered	Not Covered
Substance Abuse - Rehabilitation	Not Covered	Not Covered
Substance Abuse - Detoxification	Not Covered	Not Covered
Prescription Drug	$100 deductible/calendar year, $10 generic, $20 brand $50,000 calendar year maximum	Not Covered
Vision	Eye exam every two years Discounts on lenses and frames, non-prescription sunglasses & Laser Vision Correction Davis Vision Provider Network Only Benefit does not apply towards deductible	Not Covered
Discounts on Health-Related Services - Fitness Centers & Spas - Massage Therapy - Nutritional Counseling - Personal Trainers	Covered	Covered
Blues On Call - Health Information and Support Toll-Free Hotline	Covered	Covered

Highmark Blue Cross Blue Shield
DirectBlue Web Site Benefit Grid
$500 Deductible – Medically Underwritten

Services	**DirectBlue: An Individual Comprehensive Major Medical Preferred-Provider Health Plan; $500 Deductible; Medically Underwritten**	
	Network	**Out-of-Network**
Benefit Period	Contract Year	Contract Year
Type of Coverage	Medically Underwritten	Medically Underwritten
Deductible-Individual	$500	$500
Deductible-Family	$500/person with a maximum of $1,500	$500/person with a maximum of $1,500
Out of Pocket Maximum - Individual	$1,500 for network and out-of-network covered services combined	$1,500 for network and out-of-network covered services combined
Out of Pocket Maximum – Family	$4,500 for network and out-of-network covered services combined	$4,500 for network and out-of-network covered services combined
Coinsurance (only applied after any applicable deductibles have been met)	90%	70%
Lifetime Policy Maximum	$5,000,000 Includes out-of-network payments	$300,000 Included as part of network maximum
Benefit Period Maximum	$1,000,000 Includes out-of-network payments	Included as part of network maximum
Hospital Facility Expense – Inpatient	90% Includes maternity	70% Includes maternity
Emergency Room Care	90% after $40 copayment (waived if admitted)	90% after $40 copayment (waived if admitted)
Office/Home Visits	90%	70%
Medical/Surgical Expenses (except office visits)	90%	70%
Preventive Care	Routine Physical, Mammogram, Gynecological Exam, Pap Test and Pediatric Immunizations Deductible does not apply – 90%	Not Covered
Diagnostic Services (x-ray, lab and other tests)	90%	70%
Physical Medicine	90% 15 visits per calendar year	70% Included as part of network visits
Occupational and Speech Therapy	90% Combined 15 visits per calendar year	70% Included as part of network visits
Spinal Manipulations	90% 10 visits per calendar year	70% Included as part of network visits
Mental Health Service	Not Covered	Not Covered
Substance Abuse - Rehabilitation	Not Covered	Not Covered
Substance Abuse - Detoxification	Not Covered	Not Covered
Prescription Drug	$100 deductible/calendar year, $10 generic, $20 brand $50,000 calendar year maximum	Not Covered
Vision	Eye exam every two years – 100% -- Deductible Does Not Apply Discounts on lenses and frames, non-prescription sunglasses & Laser Vision Correction Davis Vision Provider Network Only Benefit does not apply towards deductible	Not Covered
Discounts on Health-Related Services - Fitness Centers & Spas - Massage Therapy - Nutritional Counseling - Personal Trainers	Covered	Covered
Blues On Call - Health Information and Support Toll-Free Hotline	Covered	Covered