


**Please Note:**

Some plans are subject to standard medical underwriting procedures, and acceptance is not guaranteed. Do not cancel any current health insurance coverage in reliance on this information. The information displayed here represents only a portion of the actual provisions of the coverages mentioned. This document is not a contract. The complete terms, provisions and conditions concerning the discussed coverages are described in the actual policy. Please contact us for specific requirements.

Services	CompleteCare, An Individual Comprehensive Major Medical Program; \$500 Deductible; Medically Underwritten
Benefit Period	Contract Year
Type of Coverage	Medically Underwritten
Deductible - Individual	\$500
Deductible - Family	\$500 per person with a maximum of \$1,500
Out of Pocket Maximum Individual	\$1,000
Out of Pocket Maximum Family	\$3,000
Coinsurance (only applied after any applicable deductibles have been met)	80%
Lifetime Policy Maximum	\$5,000,000
Benefit Period Maximum	\$1,000,000
Hospital Facility Expense - Inpatient (includes Maternity)	80%
Emergency Room Care	80%
Office/Home Visits	80%
Medical-Surgical Expenses (except office visits)	80%
Preventive Care	Routine Physical and Mammogram - 80% after deductible Gynecological Exam and Pap Test - 80% - deductible does not apply Pediatric Immunizations - 80% - deductible does not apply
Diagnostic Services (X-ray, lab, other tests)	80%
Physical Medicine	15 visits per calendar year
Occupational and Speech Therapy	Combined 15 visits per calendar year
Spinal Manipulations	Not Covered
Mental Health Services	Not Covered
Substance Abuse - Rehabilitation	Not Covered
Substance Abuse - Detoxification	Not Covered
Prescription Drug	\$100 deductible per calendar year 80% with \$10 minimum & \$100 maximum copayments - generic 80% with \$20 minimum & \$100 maximum copayments - brand \$50,000 calendar year maximum

<p align="center">Healthy Lifestyle - Lifestyle Improvement Classes - Discounts on Health-Related Products & Services</p>	Covered
<p align="center">Blues On Call - Health Information and Support Toll-Free Hotline</p>	Covered
	

For HIPAA eligible individuals: Health care coverage options that cover pre-existing conditions are available to individuals who meet the eligibility requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. If you live in the 29 counties of western Pennsylvania served by Highmark Blue Cross Blue Shield and meet the following guidelines, you may be eligible to purchase either ClassicBlue Traditional Hospital and Plan 100 Medical/Surgical with Major Medical coverage or ClassicBlue Traditional Hospital and Plan 100 Medical/Surgical (no Major Medical benefits). To be HIPAA eligible:

- You must have a minimum of 18 months of prior creditable health care coverage (with no breaks in coverage of more than 63 days each) and your last coverage was provided through a group, governmental or church plan.
- You must submit your completed application to Highmark Blue Cross Blue Shield within 63 days from the date that your most recent insurance coverage ended.
- You must have used all of the "COBRA" benefits available to you through your former employer.
- You are not eligible for or enrolled in Medicare, Medicaid or any other group, governmental or church health insurance plan.
- You do not have any other health insurance coverage.

If you would like more information about HIPAA, call our Member Service Department at 1-800-544-6679.

ClassicBlue Traditional - Health Coverage Tax Credit Program: The Health Coverage Tax Credit (HCTC) program, developed under the Federal Trade Act of 2002, assists displaced workers receiving Trade Adjustment Assistance (TAA) benefits and individuals receiving Pension Benefit Guaranty Corporation (PBGC) benefits with the purchase of private health insurance. The HCTC is a tax credit that covers 65 percent of the premium paid by eligible individuals for qualified health insurance coverage. If you live in the 29 counties of western Pennsylvania, you may be eligible to enroll in either ClassicBlue Traditional Hospital and Plan 100 Medical/Surgical with Major Medical coverage or ClassicBlue Traditional Hospital and Plan 100 Medical/Surgical (no Major Medical benefits). In order to have the pre-existing condition limitation waived, you must have three months of prior creditable coverage and return your application within 63 days from the date that your prior creditable coverage ended. For more information about proof of creditable coverage, see Section 4, Question 4 on the application. If you do not meet the requirements for waiving the pre-existing condition, you are still eligible to enroll, but a waiting period of one year will be imposed before benefits will be paid for any pre-existing condition. You are responsible for contacting the HCTC hotline to determine if you are eligible for the HCTC program. For complete information about eligibility, call toll-free Monday through Friday, between 8:00 a.m. and 8:00 p.m. - 1-866-628-HCTC (1-866-628-4282). Hearing impaired TTY users, call 1-866-626-4282. You can also visit the HCTC Web site at www.irs.gov/individuals/index.html and choose "Health Coverage Tax Credit."

ClassicBlue Traditional: This plan includes a pre-existing condition clause. For the first 12 months of your coverage, the Hospital and Major Medical portions of the ClassicBlue Traditional Agreement will not pay for expenses related to a condition for which you or your enrolled dependents received medical attention during the five years before you enrolled. The Medical/Surgical portion of the plan will not pay for expenses related to a condition for which you or your enrolled dependents received medical attention for one year before you enrolled.

Special Care: This program is available only to residents of western Pennsylvania who are not enrolled for any private or governmental group or individual health care plan or program as of the effective date of coverage. This coverage will not pay benefits during the first 12 months of coverage for any condition, illness or injury for which a physician rendered treatment or advice within a 12-month period prior to the effective date of the Agreement.

Note: Special Care Applicants with Children Under Age 19

Children under age 19 may qualify for free or low-cost HMO health care coverage that includes dental, vision and prescription drug benefits through CHIP (the Children's Health Insurance Program). Highmark Blue Cross Blue Shield and the Highmark Caring Foundation administer this program designed specifically for children. If you would like more

information or to request an application for children, please call 1-800-543-7105. Hearing impaired TTY users may call 1-877-323-8480.

Adults ages 19 to 65 may qualify for low-cost health care coverage that includes preventive care, doctor services, inpatient and outpatient hospital services, and accident and emergency care. To be eligible, individuals must 1) meet the program's annual income guidelines, 2) not currently be enrolled in any other health insurance including Medicaid and Medicare 3) not have had health insurance for the past 90 days (90-day restriction does not apply if your coverage was through Medicaid or CHIP or if you lost your coverage as the result of being laid-off), and 4) be a U.S. citizen or alien in lawful immigration status. There may be a waiting list for adultBasic. Please call for information, 1-800-543-7105. Hearing impaired TTY users may call 1-877-323-8480.

PreferredBlue: This Preferred Provider Program utilizes the Keystone Health Plan West network of providers. PreferredBlue includes a pre-existing condition clause. For the first 12 months of your coverage, the PreferredBlue Agreement will not pay for expenses related to a condition for which you or your enrolled dependents received medical attention during the five years before you enrolled.

PPOBlue -Medically Underwritten: This program is available to individuals who wish to purchase a qualified high deductible health plan for use with a Health Savings Account as defined by the Internal Revenue Service. This Preferred-Provider program utilizes the Keystone Health Plan West network of providers. Acceptance for PPOBlue coverage is determined by an evaluation of your medical history and other health information, as well as that of each dependent you wish to enroll. As a result, we cannot guarantee acceptance for PPOBlue. PPOBlue includes a pre-existing condition clause. For the first 12 months of your coverage, the PPOBlue Agreement will not pay for expenses related to a condition for which you or your enrolled dependents received medical attention during the five years before you enrolled.

PPOBlue - Guaranteed Issue: This program is available to individuals who wish to purchase a qualified high deductible health plan for use with a Health Savings Account as defined by the Internal Revenue Service. This Preferred-Provider program utilizes the Keystone Health Plan West network of providers. PPOBlue includes a pre-existing condition clause. For the first 12 months of your coverage, the PPOBlue Agreement will not pay for expenses related to a condition for which you or your enrolled dependents received medical attention during the five years before you enrolled.

CompleteCare: Acceptance for CompleteCare coverage is determined by an evaluation of your medical history and other health information, as well as that of each dependent you wish to enroll. As a result, we cannot guarantee acceptance for CompleteCare. CompleteCare includes a pre-existing condition clause. For the first 12 months of your coverage, the CompleteCare Agreement will not pay for expenses related to a condition for which you or your enrolled dependents received medical attention during the five years before you enrolled.

KeystoneBlue: Acceptance for KeystoneBlue coverage is determined by an evaluation of your medical history and other health information, as well as that of each dependent you wish to enroll. As a result, we cannot guarantee acceptance for KeystoneBlue. KeystoneBlue includes a pre-existing condition clause. For the first 12 months of your coverage, the KeystoneBlue Agreement will not pay for expenses related to a condition for which you or your enrolled dependents received medical attention during the five years before you enrolled.

This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered.

DirectBlue: This Preferred-Provider program utilizes the Keystone Health Plan West network of providers. Acceptance for DirectBlue coverage is determined by an evaluation of your medical history and other health information, as well as that of each dependent you wish to enroll. As a result, we cannot guarantee acceptance for DirectBlue. DirectBlue includes a pre-existing condition clause. For the first 12 months of your coverage, the DirectBlue Agreement will not pay for expenses related to a condition for which you or your enrolled dependents received medical attention during the five years before you enrolled.