

Summary of PPOBlue HDHP 80/60 Value Benefits

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period. This program is designed for individuals who wish to enroll in a qualified high deductible health plan for use with a Health Savings Account as defined by the Internal Revenue Service. Please keep in mind, with this program the Individual Deductible and Individual Out-of-Pocket Maximums only apply for a member with individual coverage. For a member with family coverage, the Family Deductible must be met by one or more members of the family before benefits will be paid. And, the Family Out-of-Pocket Maximum must be met by one or more members of the family before benefits are payable at 100%.

Benefit	Network	Out-of-Network
Benefit Period (1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$1,250 Combined	
Family	\$2,500 Combined	
Plan Payment Level – Based on the provider's reasonable charge (PRC)	80% after deductible	60% after deductible
Out-of-Pocket Maximums (Once met, plan payment level becomes 100%)		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000
Lifetime Maximum (per person)	\$5,000,000 Combined	
Primary Care Physician Office Visits	80% after deductible	60% after deductible
Specialist Office Visits	80% after deductible	60% after deductible
Preventive Care		
<i>Adult</i>		
Routine physical exams	80% (deductible does not apply)	Not Covered
Adult Immunizations	80% after deductible	60% after deductible
Routine gynecological exams, including a PAP Test	80% (deductible does not apply)	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 80% (deductible does not apply) Medically necessary: 80% after deductible	60% after deductible
<i>Pediatric</i>		
Routine physical exams	80% (deductible does not apply)	Not Covered
Pediatric immunizations	80% (deductible does not apply)	60% (deductible does not apply)
Emergency Room Services	80% after deductible	
Spinal Manipulations	80% after deductible	60% after deductible
	Limit: 20 visits/benefit period	
Physical Medicine	80% after deductible	60% after deductible
	Limit: 20 visits/benefit period	
Speech Therapy	80% after deductible	60% after deductible
	Limit: 20 visits/benefit period	
Occupational Therapy	80% after deductible	60% after deductible
	Limit: 20 visits/benefit period	
Allergy Extracts and Injections	80% after deductible	60% after deductible
Ambulance	80% after deductible	
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diabetes Treatment	80% after deductible	60% after deductible
Diagnostic Services (including routine)	80% after deductible	60% after deductible
<i>Advanced Imaging</i> (MRI, CAT Scan, PET scan, etc.)		
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible
Enteral Formulae	80% after deductible	60% after deductible
Home Infusion Therapy	80% after deductible	
Home Health Care	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Hospital Services – Inpatient	80% after deductible	60% after deductible
Hospital Services – Outpatient	80% after deductible	60% after deductible

Benefit	Network	Out-of-Network
Infertility Counseling, Testing and Treatment (2)	80% after deductible	60% after deductible
Maternity (facility & professional services)	80% after deductible	60% after deductible
Medical/Surgical Expenses (Except Office Visits)	80% after deductible	60% after deductible
Mental Health – Inpatient (3)	80% after deductible Limit: 30 days/benefit period	60% after deductible Limit: 10 days/benefit period
Mental Health – Outpatient (3)	80% after deductible Limit: 20 visits/benefit period	60% after deductible Limit: 10 visits/benefit period
Private Duty Nursing	Limit: 20 visits/benefit period 80% after deductible	
Respiratory Therapy	80% after deductible	
Skilled Nursing Facility Care	80% after deductible	60% after deductible Limit: 100 days/benefit period
Substance Abuse – Inpatient Detoxification	80% after deductible Limit: 7 days/admission; 4 admissions/lifetime	60% after deductible
Substance Abuse – Inpatient Rehabilitation	80% after deductible Limit: 30 days/benefit period; 90 days/lifetime	60% after deductible
Substance Abuse – Outpatient	80% after deductible Limit: 60 visits/benefit period; 120 visits/lifetime	60% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
Transplant Services	80% after deductible	60% after deductible
Precertification Requirements	Performed by Provider	Performed by Member(4)
Prescription Drug Deductible Individual Family	Per Calendar Year Integrated with medical deductible Integrated with medical deductible	
Premier Prescription Drug Program	<p>Defined by Premier Gold Pharmacy Network - Not Physician Network. (Prescriptions filled at a non-network pharmacy are not covered.)</p> <p>Retail Drugs(5) Plan pays 80% after deductible 31-day Supply</p> <p>Maintenance Drugs through Mail Order(5) Plan pays 80% after deductible 90-day Supply</p>	

- (1) Your group's benefit period is based on a Calendar Year. The Calendar Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
- (2) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (3) State mandated benefits (30 inpatient days and 60 outpatient visits annually with the right to exchange inpatient days for outpatient visits on a one-for-two basis) may apply to a diagnosis of serious mental illness. Serious mental illnesses include: schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa, delusional disorder. Once mental health limits are exhausted, both inpatient and outpatient serious mental illness services must be provided by a network provider (see above-referenced benefits for plan limits).
- (4) Member is required to contact Highmark Health Care Management Services prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related admission. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.
- (5) At a retail or mail order pharmacy, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. Your prescription information will be submitted to Highmark to determine if your deductible has been met. If your deductible has not been met, then the amount you paid for your prescription will be applied to your deductible. If your deductible has been met, Highmark will reimburse you based on the benefit level indicated above.

12/05

This is not intended as a Calendar of benefits. It is designed purely as a reference of the many benefits available under your program.