

Health & Prescription Drug Coverage Summary - 2010

PPO Health Plan \$250

Overview of benefits. Please review your benefits summary from Highmark for detailed coverage information, procedures, and exclusions.

	<u>In-Network Care</u> <i>Applies when treated by a participating health care provider (one who participates in the Highmark Blue Shield PPO network or, for those living out of the area, their local Blue Cross Blue Shield PPO network).</i>	<u>Out-of-Network Care</u> <i>Applies when treating with a non-participating provider.</i>
Claim Forms	Not required	Member must submit a claim form to Highmark if treatment is received from a non-participating health care provider (one who does not participate in the Highmark Blue Shield PPO network or a local Blue Cross Blue Shield network).
Coinsurance (Plan's payment / member's payment, after deductibles & co-payments are paid)	100% / 0%	70% / 30%
Deductible (per calendar year; does not apply to routine office visits, prescription medicines, vision exams, ER visits, routine mammograms, or pediatric immunizations)	\$250 per individual, up to \$500 per family	\$750 per individual, up to \$1,500 per family
Emergency and Urgent Care	Coverage provided worldwide through the Blue Cross Blue Shield - BlueCard - network of providers.	Emergency medical treatment is covered at the "coordinated care" level.
Emergency Room Co-payment (per visit; waived if admitted)	\$50	\$50
Health Education Classes	Members have access to online and other health education classes on a variety of topics. See www.highmarkblueshield.com for details.	N/A
Health Exams and Assessments	Covered at specific intervals through a participating Highmark Blue Shield PPO provider, or a Blue Cross Blue Shield provider for those living out of the area.	Lower coverage levels apply.
Hospital / Surgical / Outpatient Care	Medically necessary care is covered at the 100% level, after member's deductible is met. A \$100 inpatient hospital co-payment applies.	Medically necessary care is covered at the 70% level, after deductible is met. A \$750 inpatient hospital co-payment applies.
Inpatient Hospital Co-payment (per visit)	\$100 (plus deductible)	\$750 (plus deductible and coinsurance)
Lab Work / X-rays	Medically necessary care is covered at the 100% level, after member's deductible is met.	Medically necessary care is covered at the 70% level, after member's deductible is met.
Member Services Toll-free Number and Web Address	800-345-3806 www.highmarkblueshield.com	800-345-3806 www.highmarkblueshield.com
Mental Health and Substance Abuse Coverage	Must be authorized by Highmark <u>before</u> treatment is received. The applicable phone number is listed on the back of the Highmark ID card. Deductible and inpatient co-pay apply to inpatient care; \$20 per visit co-payment applies to outpatient care.	Must be authorized by Highmark before treatment is received. The applicable phone number is listed on the back of the Highmark ID card. Deductible, inpatient co-payment, and coinsurance apply.

	<u>In-Network Care</u>	<u>Out-of-Network Care</u>
Office Visit Co-Payments Primary Care Physician & Outpatient Mental Health: Specialist & Chiropractic Visits:	\$20 \$30	N/A (coinsurance applies) N/A (coinsurance applies)
Out-of-Pocket Maximums (maximum amount a member will pay each year for coinsurance; deductibles, co-pays, and amounts above "Reasonable & Customary" are additional) Health Insurance: Prescription Drugs:	N/A \$1,500 per individual or \$3,000 per family	\$3,500 per individual or \$10,500 per family N/A
Participant-paid Monthly Premiums	\$54.50 / month - single coverage \$108.80 / month - plus 1 dependent \$146.41 / month - family coverage	
Pediatric Immunizations	Covered per CDC guidelines (immunizations and vaccinations for adults are also covered per CDC guidelines)	Covered per CDC guidelines (immunizations and vaccinations for adults are also covered per CDC guidelines)
Physical Therapy / Rehabilitation	Coverage is provided for up to 30 outpatient visits per year; deductible applies	Coverage is provided for up to 30 outpatient visits per year; deductible applies
Pre-certification Requirements	The member's health care provider is responsible for requesting pre-certification through Highmark for certain medical services.	Pre-certification is required for all non-emergency inpatient services and outpatient surgery, procedures, and tests. The member is responsible for contacting Highmark before services are received; the member is to call the phone number listed on the back of the Highmark ID card.
Prescription Drug Co-payments (must purchase from a participating pharmacy or through the Medco mail order program)	Generic Medicine - Retail (31-day supply): 15% of drug cost w/ \$5 min. & \$15 max. per prescription; Mail Order (90-day supply): 15% of drug cost w/ \$10 min. & \$30 max. per prescription / Formulary Medicine - Retail: 25% of drug cost w/ \$20 min. & \$50 max. per prescription; Mail Order: 25% of drug cost w/ \$40 min. & \$100 max. per prescription / Non-formulary Medicine - Retail: 35% of drug cost w/ \$40 min. & \$70 max. per prescription; Mail Order: 35% of drug cost w/ \$80 min. & \$140 max. per prescription	N/A; To receive coverage, prescription medicines must be purchased from a participating pharmacy or through the Medco mail order program.
Provider's Reasonable Charges	N/A	When receiving treatment from a health care provider or facility not participating in the Highmark Blue Shield PPO or local Blue Cross Blue Shield network, the Plan pays 70% of those medical costs deemed "reasonable" by the Plan's administrative services provider, and the member must pay 30% of "reasonable" charges, plus all charges above those deemed reasonable.
Referrals	A referral is not needed when seeking care from a health care provider, including a specialist, who participates in the Highmark Blue Shield PPO network, or the local Blue Cross Blue Shield network for those living out of the area. Pre-certification requirements apply for some services.	N/A (pre-certification requirements apply)
Vision Care	If services are received from a participating NVA provider, coverage is provided for one routine vision exam per 12 months; standard glass or plastic prescription lenses every 12 months and a \$60 allowance toward frames every 24 months, or a \$75 allowance for contact lenses every 12 months in lieu of glasses. Additional discounts may apply.	If vision services are received from a non-participating provider, a lower level of coverage applies. Member must submit a claim for reimbursement to NVA.