HIGHMARK. PPOBlue A Preferred-Provider Program

Summary of Healthy Savings PPO Blue $2,600Q 90/70 Rx D *Benefits*

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period)		
Employee Only Plan	$2,600	$5,200
Family Plan	$5,200	$10,400
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Out-of-Pocket Maximums (Includes prescription drug expenses, coinsurance and copayments. Once met, plan pays 100% for the rest of the benefit period)		
Employee Only Plan	$1,000	$2,000
Family Plan	$2,000	$4,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	90% after deductible	70% after deductible
Primary Care Provider Office Visits	90% after deductible	70% after deductible
Specialist Office Visits	90% after deductible	70% after deductible
Urgent Care Center Visits	90% after deductible	70% after deductible
Preventive Care(2)		
Routine Adult		
Physical exams	100%	70% after deductible
Adult immunizations	100%	70% after deductible
Colorectal cancer screening	100%	70% after deductible
Routine gynecological exams, including a Pap Test	100%	70% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically necessary: 90% after deductible	70% after deductible
Diagnostic services and procedures	100%	70% after deductible
Routine Pediatric		
Physical exams	100%	70% after deductible
Pediatric immunizations	100%	70% (deductible does not apply)
Diagnostic services and procedures	100%	70% after deductible
Hospital and Medical/Surgical Expenses (including Maternity)		
Hospital Inpatient **Hospital Outpatient** **Maternity** (non-preventive facility & professional services) **Medical/Surgical** (except office visits)	90% after deductible	70% after deductible
Emergency Services		
Emergency Room Services	90% after deductible	
Ambulance	90% after deductible	70% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
Respiratory Therapy	90% after deductible	70% after deductible
Speech & Occupational Therapy	90% after deductible	70% after deductible
	Limit: 20 visits per therapy/benefit period	
Spinal Manipulations	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible

Benefit	Network	Out-of-Network
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	Not Covered	Not Covered
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	70% after deductible
Home Health Care	90% after deductible	70% after deductible
	Limit: 90 days/benefit period	
Hospice	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment(3)	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	Limit: 100 days/benefit period	
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements(4)	Yes	
Prescription Drugs		
Prescription Drug Deductible		
Individual	Integrated with medical deductible	
Family	Integrated with medical deductible	
Premier Prescription Drug Program(5) *Defined by the Premier 2012 Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Open Formulary.*	**Retail Drugs (31/60/90-day Supply)** You pay 10% after deductible **Maintenance Drugs through Mail Order (90-day Supply)** You pay 10% after deductible	

(1) Your group's benefit period is based on a Contract Year. The Contract 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) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.

(3) 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.

(4) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

(5) At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled.