HIGHMARK PPOBlue
A Preferred-Provider Program

Summary of Benefits

Benefits	Network	Out-of-Network
General Provisions		
Benefit Period	Calendar Year	
Deductible (per benefit period) Individual Family	 None None	 $250 $500
Plan Payment Level - Based on the provider's reasonable charge (PRC)	100%	80% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits Individual Family	 None None	 $2,000 $4,000
Lifetime Maximum (per member)	Unlimited	$1,000,000
Office Visits		
Primary Care Physician Office Visits[1]	100% after $10 copayment	80% after deductible
Specialist Office Visits	100% after $10 copayment	80% after deductible
Preventive Care Services		
Adult		
Routine physical exams	100% after $10 copayment	Not Covered
Adult Immunizations	100%	80% after deductible
Routine gynecological exams, including a PAP Test	100% after $10 copayment	80%; deductible and maximum do not apply
Mammograms, annual routine and medically necessary	100%	80% after deductible
Pediatric		
Routine physical exams	100% after $10 copayment	Not Covered
Pediatric immunizations	100%	80%; deductible and maximum do not apply
Emergency Room Services		
Emergency Room Services	100% after $35 copayment (waived if admitted)	Same as network services
Hospital Services		
Hospital Services - Inpatient	100%	80% after deductible
Hospital Services - Outpatient[2]	100%	80% after deductible
Therapy and Rehabilitation Services		
Spinal Manipulations	100% after $10 copayment	80% after deductible
	Combined Limit: 20 visits per benefit period	
Physical Medicine	100% after $10 copayment	80% after deductible
	Combined Limit: 20 visits per benefit period	
Speech Therapy	100% after $10 copayment	80% after deductible
	Combined Limit: 20 visits per benefit period	
Occupational Therapy	100% after $10 copayment	80% after deductible
	Combined Limit: 20 visits per benefit period	
Cardiac Rehabilitation, Chemotherapy, and Dialysis Treatment	100%	80% after deductible
Infusion Therapy	100%	80% after deductible
Radiation Therapy	100%	80% after deductible
Respiratory Therapy	100%	100%; deductible does not apply

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Benefits	Network	Out-of-Network
Diagnostic Services		
Diagnostic Services (including routine and pre-admission testing) (Lab, x-ray, allergy testing and other diagnostic medical tests)	100%	80% after deductible
Behavioral Health Services		
Mental Health Care Services - Inpatient[3]	100%	80% after deductible
	Limit: 30 days per benefit period	Limit: 10 days per benefit period
	Combined limit: 30 days per benefit period	
Mental Health Care Services - Outpatient	100% after $10 copayment	80% after deductible
	Limit: 20 visits per benefit period	Limit: 10 visits per benefit period
	Combined Limit: 20 visits per benefit period	
Substance Abuse Services - Inpatient Detoxification	100%	80% after deductible
	Combined Limit: 7 days per admission; 4 admissions per lifetime	
Substance Abuse Services - Inpatient Residential Treatment and Rehabilitation Services	100%	80% after deductible
	Combined Limit: 30 days per benefit period; 90 days per lifetime	
Substance Abuse Services - Outpatient[4]	100% after $10 copayment	80% after deductible
	Combined Limit: 60 visits per benefit period; 120 visits per lifetime	
Other Services		
Allergy Extracts and Injections	100%	80% after deductible
Assisted Fertilization Treatment	Not Covered	
Ambulance	100%	100%; deductible does not apply
Dental Services Related to Accidental Injury	100%	80% after deductible
Diabetes Treatment	100%	80% after deductible
Dr. Dean Ornish Program For Reversing Heart Disease[5]	100%	Same as network services
	Maximum of one enrollment per lifetime	
Durable Medical Equipment	100%	80% after deductible
Enteral Formulae	100%	80%; deductible does not apply
Home Infusion Therapy	100%	100%; deductible does not apply
Home Health Care[6]	100%	100%; deductible does not apply
Hospice	100%	100%; deductible does not apply
Infertility Counseling, Testing and Treatment[7]	100%	80% after deductible
Maternity (facility and professional services)	100%	80% after deductible
Orthotics	100%	80% after deductible
Pediatric Extended Care Services	100%	80% after deductible
	Combined Limit: 100 days per benefit period	
Private Duty Nursing	100%	100%; deductible does not apply
Prosthetics	100%	80% after deductible
Skilled Nursing Facility Care	100%	80% after deductible
		Limit: 100 days per benefit period
Medical/Surgical Expenses (except office visits)	100%	80% after deductible

Benefits	Network	Out-of-Network
Transplant Services	100%	80% after deductible
Precertification Requirements	Yes[8]	

1 A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.

2 Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.

3 State-mandated benefits (30 inpatient days and 60 outpatient visits per benefit period, with the right to exchange inpatient days for outpatient visits on a one-for-two basis) 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 and delusional disorder. Once mental health limits are exhausted, both inpatient and outpatient serious mental illness services must be provided by a network provider (see Summary of Benefits for program limits).

4 Of the 60 outpatient visits or equivalent partial visits or partial hospitalization services per benefit period, a maximum of 30 of these visits may be exchanged on a two-for-one basis to secure up to 15 additional days per benefit period beyond the 30-day limit for inpatient non-hospital rehabilitation services.

5 The program may be subject to class size limits and is only offered at selected sites. Therefore, the availability of a Dr. Dean Ornish participating provider within a particular geographic area may be limited.

6 The maternity home health care visit for network care is not subject to the program copayment, coinsurance or deductible amounts, if applicable. See Maternity Home Health Care Visit in the Covered Services section.

7 If testing is required, cost sharing may apply as outlined under Diagnostic Services. 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.

8 Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. 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.