

# 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
<b>General Provisions</b>		
<b>Benefit Period</b> <sup>(1)</sup>	Contract Year	
<b>Deductible</b> (per benefit period)		
Employee Only Plan	\$2,600	\$5,200
Family Plan	\$5,200	\$10,400
<b>Plan Pays</b> – payment based on the plan allowance	90% after deductible	70% after deductible
<b>Out-of-Pocket Maximums</b> (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
<b>Office/Clinic/Urgent Care Visits</b>		
<b>Retail Clinic Visits</b>	90% after deductible	70% after deductible
<b>Primary Care Provider Office Visits</b>	90% after deductible	70% after deductible
<b>Specialist Office Visits</b>	90% after deductible	70% after deductible
<b>Urgent Care Center Visits</b>	90% after deductible	70% after deductible
<b>Preventive Care</b> <sup>(2)</sup>		
<b>Routine Adult</b>		
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
<b>Routine Pediatric</b>		
Physical exams	100%	70% after deductible
Pediatric immunizations	100%	70% (deductible does not apply)
Diagnostic services and procedures	100%	70% after deductible
<b>Hospital and Medical/Surgical Expenses (including Maternity)</b>		
<b>Hospital Inpatient</b>		
<b>Hospital Outpatient</b>		
<b>Maternity</b> (non-preventive facility & professional services)	90% after deductible	70% after deductible
<b>Medical/Surgical</b> (except office visits)		
<b>Emergency Services</b>		
<b>Emergency Room Services</b>	90% after deductible	
<b>Ambulance</b>	90% after deductible	70% after deductible
<b>Therapy and Rehabilitation Services</b>		
<b>Physical Medicine</b>	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
<b>Respiratory Therapy</b>	90% after deductible	70% after deductible
<b>Speech &amp; Occupational Therapy</b>	90% after deductible	70% after deductible
	Limit: 20 visits per therapy/benefit period	
<b>Spinal Manipulations</b>	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
<b>Other Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible

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