

Blue Cross Blue Shield

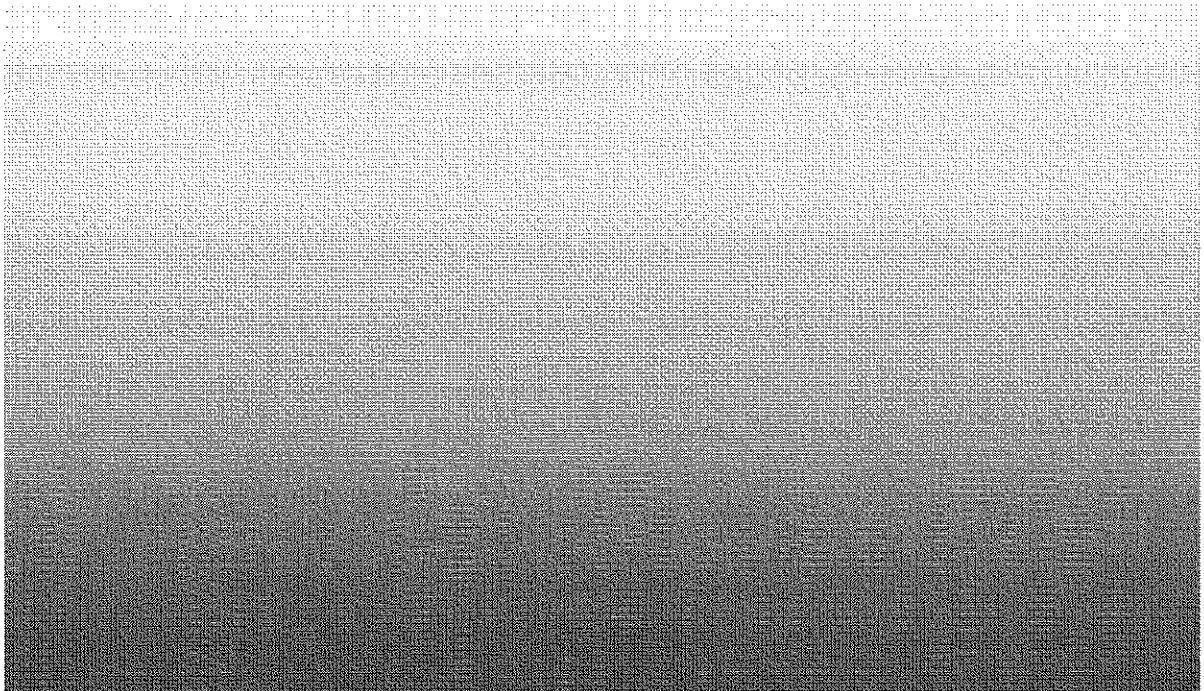
PPO Program

Hoss's Steak and Sea House

Group 16405-01, 71

Effective January 1, 2010

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*Highmark Blue Cross Blue Shield is an Independent
Licensee of the Blue Cross and Blue Shield Association.*

Language Assistance Services Available for Multiple Languages

ENGLISH

Please Read This Important Message

It is important for you to understand all of the enclosed information about your health care coverage. This information includes rights you have and requirements you must meet to take full advantage of your health care benefits.

Language services are available to you, free of charge, upon request. Call the toll-free phone number on the back of your identification card for help.

SPANISH

Lea este importante mensaje

Es importante que comprenda toda la información adjunta sobre su cobertura de atención de salud. Esta información incluye los derechos con los que usted cuenta y los requisitos que debe cumplir para aprovechar al máximo los beneficios de atención de salud.

Si los solicita, se encuentran a su disposición servicios de idiomas gratuitos. Llame al número de teléfono gratuito en el reverso de su tarjeta de identificación.

VIETNAMESE

Xin Đọc Tin Nhấn Quan Trọng Đây

Điều quan trọng là quý vị hiểu rõ tất cả các thông tin đính kèm về bảo hiểm sức khỏe của quý vị. Thông tin này bao gồm quyền lợi mà quý vị được và các đòi hỏi mà quý vị cần đáp ứng để tận dụng toàn bộ các quyền lợi chăm sóc sức khỏe của mình.

Quý vị sẽ được dịch vụ về ngôn ngữ miễn phí khi yêu cầu. Xin gọi số điện thoại miễn phí ghi ở phía sau thẻ ID của quý vị để được giúp đỡ.

RUSSIAN

Пожалуйста, ознакомьтесь с этой важной информацией

Очень важно, чтобы Вы хорошо понимали всю информацию, которая изложена в приложении и описывает Вашу программу страхового медицинского покрытия. В этой информации представлены права, которые Вам предоставлены, а также условия, которым Вы должны соответствовать, чтобы получить полный доступ к страховому медицинскому покрытию.

Вы имеете возможность воспользоваться языковыми услугами, которые предоставляются бесплатно и по требованию. Позвоните по бесплатному номеру телефона, указанному на обороте Вашей идентификационной карты, чтобы получить эту помощь.

ITALIAN

Leggere attentamente il presente messaggio

E' molto importante che comprenda perfettamente le informazioni allegate relative alla sua copertura sanitaria. Tali informazioni includono i diritti in suo possesso e i requisiti da soddisfare per usufruire dei vantaggi offerti dalla sua copertura sanitaria.

Sono disponibili servizi linguistici gratuiti su richiesta. Chiami il numero verde gratuito sul retro della sua tessera identificativa per un'ulteriore assistenza.

CHINESE (MANDARIN/SIMPLIFIED)

请阅读以下重要信息

理解随附的所有有关您的健康护理保赔的信息十分重要。该信息包括您享有的权利以及充分利用您的健康护理福利必须符合的要求。

可应您的请求免费向您提供语言服务。请拨印在您的会员卡背面的免费电话号码，获取帮助。

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This Booklet is not a Contract

This booklet does not constitute a contract of benefits and provisions. The complete set of terms of coverage are set forth in the Group Contract issued by Highmark Blue Cross Blue Shield, an Independent Licensee of the Blue Cross and Blue Shield Association. This booklet is merely a description of the principal features of your PPO program.

Introduction to Your PPO Program

This booklet provides you with the information you need to understand your Highmark Blue Cross Blue Shield PPO program. We encourage you to take the time to review this information so you understand how your health care program works.

For a number of reasons, we think you'll be pleased with your health care program:

- ***Your PPO program gives you freedom of choice.*** You are not required to select a primary care physician to receive covered care. You have access to a large provider network of physicians, hospitals, and other providers throughout the country. For a higher level of coverage, you need to receive care from one of these network providers. However, you can go outside the network and still receive care at the lower level of coverage. To locate a network provider near you, or to learn whether your current physician is in the network, call 1-800-810-BLUE (2583), log onto www.bcbs.com, or log onto Highmark's Web site, www.highmarkbcbs.com.
- ***Your PPO program gives you "stay healthy" care.*** You are covered for a range of preventive care, including physical examinations and selected diagnostic tests. Preventive care is a proactive approach to health management that can save you time and medical expenses down the road.

And, as a Highmark member, you get important extras. Along with 24-hour assistance with any health care question or concern via Blues On Callsm, your member Web site connects you to a range of self-service tools that can help you manage your coverage. The Web site also offers programs and services designed to help you "Have A Greater Hand in Your Health[®]" by helping you make and maintain healthy improvements.

You can review Preventive Care Guidelines, check eligibility information, order ID cards, medical and drug claim forms, even review claims and Explanation of Benefits (EOB) information all online. You can also access health information such as the comprehensive Healthwise Knowledgebase[®], full-color Health Encyclopedia, and the Health Crossroads[®] guide to treatment options. You can take an online Lifestyle Improvement course to manage stress, stop smoking or improve your nutrition. And the Web site connects you to a wide range of cost and quality tools to assure you spend your health care dollars wisely.

We understand that prescription drug coverage is of particular concern to our members. You'll find in-depth information on these benefits in this booklet.

If you have any questions on your PPO program, please call the Member Service toll-free telephone number on the back of your ID card.

Information for Non-English-Speaking Members

Non-English-speaking members have access to clear benefits information. They can call the toll-free Member Service telephone number on the back of their ID card to be connected to a language services interpreter line. Highmark Member Service representatives are trained to make the connection.

As always, we value you as a member, look forward to providing your coverage, and wish you good health.

How Your Benefits Are Applied

To help you understand your coverage and how it works, here's an explanation of some benefit terms found in your Summary of Benefits.

Benefit Period

The specified period of time during which charges for covered services must be incurred in order to be eligible for payment by Highmark Blue Cross Blue Shield. A charge shall be considered incurred on the date you receive the service or supply for which the charge is made.

Your benefit period is 12 consecutive months beginning on January 1.

Medical Cost-Sharing Provisions

Cost-sharing is a requirement that you pay part of your expenses for covered services. The terms "copayment," "deductible" and "coinsurance" describe methods of such payment.

Coinsurance

The coinsurance is the specific percentage of the provider's reasonable charge for covered services that is your responsibility. You may be required to pay any applicable coinsurance at the time you receive care from a provider. Refer to the Plan Payment Level in your Summary of Benefits for the percentage amounts paid by the program.

Copayment

The copayment for certain covered services is the specific, upfront dollar amount which will be deducted from the provider's reasonable charge by your PPO program and is your responsibility. You may be responsible for multiple copayments per visit. See your Summary of Benefits for the copayment amounts.

The copayment does not apply toward your deductible or coinsurance, and does not accumulate toward the out-of-pocket limit. **You are expected to pay your copayment to the provider at the time of service.**

Deductible

The deductible is a specified dollar amount you must pay for covered services each benefit period before the program begins to provide payment for benefits. See the Summary of Benefits for the deductible amount. You may be required to pay any applicable deductible at the time you receive care from a provider.

Expenses for covered services incurred during the last three months of a benefit period will be credited toward the network and out-of-network deductible required in the following benefit period.

If your group changes group health care expense coverage during your benefit period, the amount you paid toward your deductible during the last partial benefit period for services covered under the prior Highmark coverage will be applied to the network and out-of-network deductible of the initial benefit period under this program.

Family Deductible

For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under family deductible. To reach this total, you can count the expenses incurred by two or more covered family members. However, the deductible contributed towards the total by any one covered family member will not be more than the amount of the individual deductible. If one family member meets the individual deductible and needs to use benefits, the program would begin to pay for that person's covered services even if the deductible for the entire family has not been met.

When two or more covered family members are injured in the same accident, only one deductible will be applied to the aggregate of such charges.

Out-of-Pocket Limit

The out-of-pocket limit refers to the specified dollar amount of coinsurance incurred for covered services in a benefit period. When the specified dollar amount is attained, Highmark begins to pay 100% of all covered expenses. See your Summary of Benefits for the out-of-pocket limit. The out-of-pocket limit does not include copayments, deductibles, prescription drug expenses or amounts in excess of the provider's reasonable charge.

Family Out-of-Pocket Limit

The family out-of-pocket limit refers to the amount of coinsurance incurred by you or your covered family members for covered services received in a benefit period.

Once all covered family members have incurred an amount equal to the family out-of-pocket limit, claims received by Highmark for all covered family members during the remainder of the benefit period will be payable at 100% of the provider's reasonable charge.

If your group changes group health care expense coverage during your benefit period, the amount you paid toward your out-of-pocket limit during the last partial benefit period for services covered under the prior Highmark coverage will be applied to the network and out-of-network (combined) out-of-pocket limit of the initial benefit period under this program.

Maximum

The greatest amount of benefits that the program will provide for covered services within a prescribed period of time. This could be expressed in dollars, number of days or number of services.

Lifetime Maximum

The maximum benefit that the program will provide for any covered individual during his or her lifetime is specified in your Summary of Benefits.

At the start of each benefit period, the amount paid for covered services in the preceding benefit period (up to \$1,000) will be restored to the lifetime maximum of each person who used the benefits.

The amount paid for covered services for any individual covered under this program will be added to any amount paid for benefits for that same individual under any other group health care expense program between the group and Highmark, for the purpose of calculating the benefit period or lifetime maximum applicable to each individual.

Prescription Drug Cost-Sharing Provisions

Cost-sharing is a requirement that you pay part of your covered expenses. The following provision(s) describe the methods of such payment.

Prescription drug benefits are not subject to the overall program deductible, coinsurance or maximum.

Coinsurance

The coinsurance is the specific percentage of the provider's allowable price for covered medications that is your responsibility. See your Summary of Benefits for coinsurance amounts.

Minimum/Maximum Member Liability for Drug Coinsurance

You are responsible for a percentage, ie, 20%, of the provider's allowable price of every covered prescription drug. However, your program includes a maximum member liability amount for each covered prescription drug, ie, \$50 to limit your liability on very expensive prescription drugs, and a minimum member liability amount for each covered prescription drug, ie, \$15, that will establish your responsibility on less expensive prescription drugs. Your minimum coinsurance obligation is the amount specified in the Summary of Benefits, or the cost of the covered prescription drug, whichever is lower.

Here is how it works. Consider a 20% coinsurance with a \$15 minimum and a \$50 maximum. If your prescription costs less than \$15, you will pay the actual cost of the prescription. If your prescription costs between \$15 and \$75, you will pay \$15 since 20%

of \$75 is \$15 and that is the minimum coinsurance. If your prescription costs between \$75 and \$250, you will pay 20% of the actual prescription cost.

The maximum member liability amount for coinsurance is the highest coinsurance amount that is your responsibility. Therefore, if your prescription costs more than \$250, you will pay \$50 (since 20% of \$250 is \$50 and that is a maximum amount you will pay for coinsurance for each prescription drug).

Deductible

The deductible is a specified dollar amount you must pay for covered medications each benefit period before the program begins to provide payment for covered medications. See your Summary of Benefits for the deductible amount.

Family Deductible

For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under family deductible. To reach this total, you can count the expenses incurred by two or more covered family members. However, the deductible contributed towards the total by any one covered family member will not be more than the amount of the individual deductible. If one family member meets the individual deductible and needs to use benefits, the program would begin to pay for that person's covered expenses even if the deductible for the entire family has not been met.

Laws Affecting Program Benefits

Employees in certain states may be subject to state and federal laws which impact health insurance coverage. The benefits of this program will be modified to reflect the provision of such laws.

Summary of Benefits

This Summary of Benefits is a brief description of covered services. More details can be found in the Covered Services section.

Benefits	Network	Out-of-Network
General Provisions		
Benefit Period¹	Contract Year	
Deductible (per benefit period)		
Individual	\$250	\$500
Family	\$500	\$1,000
Plan Payment Level - Based on the provider's reasonable charge (PRC)	80% after deductible until out-of-pocket limit is met; then 100%	60% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits		
Individual	\$1,500	\$4,000
Family	\$3,000	\$8,000
Autism Spectrum Disorders maximum (per member) ²	\$36,000 maximum per benefit period (includes prescription drug expenses)	
Lifetime Maximum (per member)	Unlimited	\$1,000,000
Office Visits		
Primary Care Physician Office Visits³	100% after \$25 copayment; deductible does not apply	60% after deductible
Specialist Office Visits	100% after \$25 copayment; deductible does not apply	60% after deductible
Preventive Care Services		
Adult		
Routine physical exams	100%; deductible does not apply	Not Covered
Adult Immunizations	80% after deductible	60% after deductible
Routine gynecological exams, including a PAP Test	100% after \$25 copayment; deductible does not apply	60%; deductible and maximum do not apply
Mammograms, annual routine and medically necessary	100%; deductible does not apply	60% after deductible
Colorectal Cancer Screening, routine and medically necessary	80% after deductible	60% after deductible
Pediatric		
Routine physical exams	100%; deductible does not apply	Not Covered
Pediatric immunizations	100%; deductible does not apply	60%; deductible and maximum do not apply
Emergency Room Services		
Emergency Room Services	100% after \$100 copayment (waived if admitted as an inpatient); deductible does not apply	Same as network services
Hospital Services		
Hospital Services - Inpatient	80% after deductible	60% after deductible
Hospital Services - Outpatient⁴	80% after deductible	60% after deductible
Therapy and Rehabilitation Services		
Spinal Manipulations	100% after \$25 copayment; deductible does not apply	60% after deductible
	Combined Limit: 20 visits per benefit period	
Physical Medicine	100% after \$25 copayment; deductible does not apply	60% after deductible
	Combined Limit: 20 visits per benefit period	
Speech Therapy	100% after \$25 copayment; deductible does not apply	60% after deductible
	Combined Limit: 20 visits per benefit period	

Benefits	Network	Out-of-Network
Occupational Therapy	100% after \$25 copayment; deductible does not apply	60% after deductible
Combined Limit: 20 visits per benefit period		
Cardiac Rehabilitation, Chemotherapy, and Dialysis Treatment	80% after deductible	60% after deductible
Infusion Therapy	80% after deductible	60% after deductible
Radiation Therapy	80% after deductible	60% after deductible
Respiratory Therapy	80% after deductible	Same as network services
Diagnostic Services		
Diagnostic Services (including routine and pre-admission testing) (Lab, x-ray, allergy testing and other diagnostic medical tests)	80% after deductible	60% after deductible
Behavioral Health Services		
Mental Health Care Services - Inpatient⁵	80% after deductible	60% after deductible
Mental Health Care Services - Outpatient	100% after \$25 copayment; deductible does not apply	60% after deductible
Substance Abuse Services - Inpatient Detoxification	80% after deductible	60% after deductible
Substance Abuse Services - Inpatient Residential Treatment and Rehabilitation Services	80% after deductible	60% after deductible
Substance Abuse Services - Outpatient	100% after \$25 copayment; deductible does not apply	60% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	60% after deductible
Applied Behavior Analysis for Autism Spectrum Disorders (ASD)²	80% after deductible	60% after deductible
Assisted Fertilization Treatment	Not Covered	
Ambulance	80% after deductible	Same as network services
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diabetes Treatment	80% after deductible	60% after deductible
Dr. Dean Ornish Program For Reversing Heart Disease⁶	80% after deductible	Same as network services
Maximum of one enrollment per lifetime		
Durable Medical Equipment	80% after deductible	60% after deductible
Enteral Formulae	80%; deductible does not apply	60%; deductible does not apply
Home Infusion Therapy	80% after deductible	Same as network services
Home Health Care⁷	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment⁸	80% after deductible	60% after deductible
Maternity (facility and professional services)	80% after deductible	60% after deductible
Orthotics	80% after deductible	60% after deductible
Pediatric Extended Care Services	80% after deductible	60% after deductible
Combined Limit: 100 days per benefit period		
Private Duty Nursing	80% after deductible	Same as network services
Prosthetics	80% after deductible	60% after deductible
Skilled Nursing Facility Care	80% after deductible	60% after deductible
Limit: 100 days per benefit period		

Benefits	Network	Out-of-Network
Medical/Surgical Expenses (except office visits)	80% after deductible	60% after deductible
Transplant Services	80% after deductible	60% after deductible
Precertification Requirements	Yes ⁹	

- ¹ Your group's benefit period is based on a contract year. The contract year is a consecutive 12-month period beginning on January 1.
- ² Coverage for eligible members to age 21. Services will be paid according to the benefit category, i.e., speech therapy. Treatment for autism spectrum disorders does not reduce visit/day limits.
- ³ A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.
- ⁴ Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.
- ⁵ State-mandated minimum benefits apply to a diagnosis of serious mental illness. Serious mental illnesses include: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder. (If the above grid does not show a limit, your mental health benefit days and visits are unlimited.)
- ⁶ 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.
- ⁷ 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.
- ⁸ 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.
- ⁹ 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.

Prescription Drug Benefits	Benefits available through the Premier Pharmacy Network only Mandatory Generic ¹
Benefit Period	Calendar Year
Deductible (per benefit period) <i>Combined Retail and Mail Order</i>	\$100 Individual \$200 Family
Retail Pharmacy	Up to 31-day supply
Coinsurance - Based on the provider's allowable price	20% generic 30% brand
	Retail Minimums
Minimum Generic Coinsurance	\$15 payment per prescription
Minimum Brand Coinsurance	\$15 payment per prescription
	Retail Maximums
Maximum Generic Coinsurance	\$100 payment per prescription
Maximum Brand Coinsurance	\$100 payment per prescription
Maintenance Prescription Drugs through Mail Order	Up to 90-day supply
Coinsurance - Based on the provider's allowable price	20% generic 30% brand
	Maintenance Drug Minimums
Minimum Generic Coinsurance	\$30 payment per prescription
Minimum Brand Coinsurance	\$30 payment per prescription
	Maintenance Drug Maximums
Maximum Generic Coinsurance	\$200 payment per prescription
Maximum Brand Coinsurance	\$200 payment per prescription

¹ You are responsible for the payment differential when a generic drug is authorized by the physician and the patient purchases a brand name drug. Your payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or coinsurance amounts which may apply.

Covered Services - Medical Program

Your PPO program provides benefits for the following services you receive from a provider when such services are determined to be medically necessary and appropriate. All benefit limits, deductibles and copayment amounts are described in the Summary of Benefits. Network care is covered at a higher level of benefits than out-of-network care.

Ambulance Service

Ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

- from your home, the scene of an accident or medical emergency to a hospital or skilled nursing facility;
- between hospitals; or
- between a hospital and a skilled nursing facility;

when such facility is the closest institution that can provide covered services appropriate for your condition. If there is no facility in the local area that can provide covered services appropriate for your condition, then ambulance service means transportation to the closest facility outside the local area that can provide the necessary service.

Local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

- from a hospital to your home, or
- from a skilled nursing facility to your home.

Autism Spectrum Disorders

Benefits are provided to members under 21 years of age for the following:

Diagnostic Assessment of Autism Spectrum Disorders

Medically necessary and appropriate assessments, evaluations or tests performed by a physician, licensed physician assistant, psychologist or certified registered nurse practitioner to diagnose whether an individual has an autism spectrum disorder.

Treatment of Autism Spectrum Disorders

Services must be specified in a treatment plan developed by a physician or psychologist following a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of

Pediatrics. Highmark may review a treatment plan for autism spectrum disorders once every six months, or as agreed upon between Highmark and the physician or psychologist developing the treatment plan.

Treatment may include the following medically necessary and appropriate services:

Pharmacy care

Any assessment, evaluation or test prescribed or ordered by a physician, licensed physician assistant or certified registered nurse practitioner to determine the need or effectiveness of a prescription drug approved by the Food and Drug Administration (FDA) and designated by Highmark for the treatment of autism spectrum disorders.

Psychiatric and psychological care

Direct or consultative services provided by a psychologist or by a physician who specializes in psychiatry.

Rehabilitative care

Professional services and treatment programs, including Applied Behavioral Analysis, provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.

Therapeutic care

Services that are provided by a speech language pathologist, occupational therapist or physical therapist.

Dental Services Related to Accidental Injury

Dental services rendered by a physician or dentist which are required as a result of accidental injury to the jaws, sound natural teeth, mouth or face. Injury as a result of chewing or biting shall not be considered an accidental injury.

Diabetes Treatment

Coverage is provided for the following when required in connection with the treatment of diabetes and when prescribed by a physician legally authorized to prescribe such items under the law:

- Equipment and supplies: Blood glucose monitors, monitor supplies, and insulin infusion devices
- Diabetes Education Program*: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through a diabetes education program:
 - Visits medically necessary and appropriate upon the diagnosis of diabetes

- Subsequent visits under circumstances whereby your physician: a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in your self-management, or b) identifies, as medically necessary and appropriate, a new medication or therapeutic process relating to your treatment and/or management of diabetes

***Diabetes Education Program** – an outpatient program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such outpatient program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to Highmark Blue Cross Blue Shield's criteria. These criteria are based on the certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA).

Diagnostic Services

Benefits will be provided for the following covered services when ordered by a professional provider:

- Diagnostic x-ray consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine
- Diagnostic pathology consisting of laboratory and pathology tests
- Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by Highmark
- Allergy testing consisting of percutaneous, intracutaneous, and patch tests

Dr. Dean Ornish Program (For Reversing Heart Disease)®

- The Dr. Dean Ornish Program (For Reversing Heart Disease) is a comprehensive lifestyle modification program which emphasizes nutritional counseling, therapeutic exercise, stress management techniques, and regular participation in a professionally supervised support group, on an outpatient basis. It is designed to assist you in the management of coronary artery disease and/or to address key risk factors associated with the onset and progression of coronary artery disease.
- The program requires a minimum one year participation commitment and must be provided by a Dr. Dean Ornish participating provider.
- Coverage will be provided if you meet the specific benefit eligibility criteria and receive the approval of your attending physician.

- Coverage is limited to a one time enrollment in the program per lifetime, regardless of whether you complete the program.
- 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.

Durable Medical Equipment

The rental or, at the option of Highmark, the purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use when prescribed by a professional provider within the scope of his/her license. Rental costs can not exceed the total cost of purchase.

Enteral Formulae

Enteral formulae is a liquid source of nutrition administered under the direction of a physician that may contain some or all of the nutrients necessary to meet minimum daily nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube.

Coverage is provided for enteral formulae when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders. Benefits are exempt from all deductible requirements.

Additional coverage for enteral formulae is provided when administered on an outpatient basis, when medically necessary and appropriate for your medical condition, when considered to be your sole source of nutrition and:

- when provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulae; or
- when provided orally and identified as one of the following types of defined formulae:
 - with hydrolyzed (pre-digested) protein or amino acids; or
 - with specialized content for special metabolic needs; or
 - with modular components; or
 - with standardized nutrients.

Once it is determined that you meet the above criteria, coverage for enteral formulae will continue as long as it represents at least 50% of your daily caloric requirement.

Additional coverage for enteral formulae excludes the following:

- Blenderized food, baby food, or regular shelf food when used with an enteral system
- Milk or soy-based infant formulae with intact proteins
- Any formulae, when used for the convenience of you or your family members
- Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance
- Semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally
- Normal food products used in the dietary management of rare hereditary genetic metabolic disorders

Home Health Care/Hospice Care Services

This program covers the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care:

- Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN), excluding private duty nursing services
- Physical medicine, speech therapy and occupational therapy
- Medical and surgical supplies provided by the home health care agency or hospital program for home health care or hospice care
- Oxygen and its administration
- Medical social service consultations
- Health aide services when you are also receiving covered nursing services or therapy and rehabilitation services
- Family counseling related to the member's terminal condition

No home health care/hospice benefits will be provided for:

- dietitian services;
- homemaker services;
- maintenance therapy;

- dialysis treatment;
- custodial care; and
- food or home-delivered meals.

Home Infusion Therapy Services

Benefits will be provided when performed by a home infusion therapy provider in a home setting. This includes pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with home infusion therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with home infusion therapy.

Hospital Services

This program covers the following services received in a facility provider. Benefits will be covered only when, and so long as, they are determined to be medically necessary and appropriate for the treatment of the patient's condition.

Inpatient Services

Bed and Board

Bed, board and general nursing services are covered when you occupy:

- a room with two or more beds;
- a private room. Private room allowance is the average semi-private room charge;
- a bed in a special care unit which is a designated unit which has concentrated all facilities, equipment and supportive services for the provision of an intensive level of care for critically ill patients.

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms and equipment;
- drugs and medicines provided to you while you are an inpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;
- medical and surgical dressings, supplies, casts and splints;

- diagnostic services; or
- therapy and rehabilitation services.

Outpatient Services

Ancillary Services

Hospital services and supplies including, but not restricted to:

- use of operating, delivery and treatment rooms, offices and other facility settings, and equipment;
- drugs and medicines provided to you while you are an outpatient in a facility provider;
- whole blood, administration of blood, blood processing, and blood derivatives;
- anesthesia, anesthesia supplies and services rendered in a facility provider by an employee of the facility provider. Administration of anesthesia ordered by the attending professional provider and rendered by a professional provider other than the surgeon or assistant at surgery;
- medical and surgical dressings, supplies, casts and splints.

Pre-Admission Testing

Tests and studies required in connection with your admission rendered or accepted by a hospital on an outpatient basis prior to a scheduled admission to the hospital as an inpatient.

Surgery

Hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, anesthesia supplies and services rendered by an employee of the facility provider, other than the surgeon or assistant at surgery.

Emergency Care Services

As a PPO member, you're covered at the higher, network level of benefits for emergency care received in *or outside* the provider network. This flexibility helps accommodate your needs when you need care *immediately*.

Your outpatient emergency room visits may be subject to a copayment, which is waived if you are admitted as an inpatient. (Refer to the Summary of Benefits section for your program's specific amounts.)

In true emergency situations, where you must be treated immediately, go directly to your nearest hospital emergency provider; or call "911" or your area's emergency number.

Once the crisis has passed, call your physician to receive appropriate follow-up care.

Emergency Accident Care

Services and supplies, including drugs and medicines, for the outpatient emergency treatment of bodily injuries resulting from an accident.

Emergency Medical Care

Services and supplies, including drugs and medicines, for the outpatient emergency treatment of a medical condition manifesting itself by acute symptoms that require immediate medical attention and with which the absence of immediate medical attention could reasonably result in:

- placing the patient's health in jeopardy;
- causing serious impairment to bodily functions;
- causing serious dysfunction of any bodily organ or part; or
- causing other serious medical consequences.

Maternity Services

If you are pregnant, now is the time to enroll in the Baby BluePrints® Maternity Education and Support Program offered by Highmark. Please refer to the Member Services section of this booklet for more information.

If you think you are pregnant, you may contact your physician or go to a network obstetrician or nurse midwife. When your pregnancy is confirmed, you may continue to receive follow-up care which includes prenatal visits, medically necessary and appropriate sonograms, delivery, postpartum and newborn care in the hospital that is covered at the maximum level of benefits.

Hospital, medical and surgical services rendered by a facility provider or professional provider for:

Complications of Pregnancy

Physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

Normal Pregnancy

Normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but is not considered a complication of pregnancy.

Nursery Care

Covered services provided to the newborn child from the moment of birth, including care which is necessary for the treatment of medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care. Routine nursery care includes inpatient medical visits by a professional provider. Benefits will continue for a maximum of 31 days. To be covered as a dependent beyond the 31-day period, the newborn child must be enrolled as a dependent under this program within such period. Refer to the General Information section for further eligibility information.

Maternity Home Health Care Visit

You are covered for one maternity home health care visit provided at your home within 48 hours of discharge when the discharge from a facility provider occurs prior to: (a) 48 hours of inpatient care following a normal vaginal delivery, or (b) 96 hours of inpatient care following a cesarean delivery. This visit shall be made by a network provider whose scope of practice includes postpartum care. The visit includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance of any necessary maternal and neonatal physical assessments. The visit may, at your sole discretion, occur at the office of your network provider. The visit is subject to all the terms of this program and is exempt from any copayment, coinsurance or deductible amounts.

Under state law, entities such as Highmark, which issue health insurance to your employer or union, are generally prohibited from restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, state law does not prohibit the mother's or newborn's attending provider from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable) if the mother and newborn meet the medical criteria for a safe discharge contained in guidelines which recognize treatment standards used to determine the appropriate length of stay; including those of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. In any case, health insurance issuers like Highmark can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

Medical Services

Inpatient Medical Services

Medical care by a professional provider when you are an inpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided herein:

Concurrent Care

Medical care rendered concurrently with surgery during one inpatient stay by a professional provider other than the operating surgeon for treatment of a medical condition separate from the condition for which surgery was performed. Medical care

by two or more professional providers rendered concurrently during one inpatient stay when the nature or severity of your condition requires the skills of separate physicians.

Consultation

Consultation services rendered to an inpatient by another professional provider at the request of the attending professional provider. Consultation does not include staff consultations which are required by facility provider rules and regulations. Benefits are limited to one consultation per consultant per admission.

Inpatient Medical Care Visits

Intensive Medical Care

Medical care rendered to you when your condition requires a professional provider's constant attendance and treatment for a prolonged period of time.

Routine Newborn Care

Professional provider visits to examine the newborn infant while the mother is an inpatient.

Outpatient Medical Care Services (Office Visits)

Medical care rendered by a professional provider when you are an outpatient for a condition not related to surgery, pregnancy or mental illness, except as specifically provided. Benefits include medical care visits and consultations for the examination, diagnosis and treatment of an injury or illness.

Please note that as a Highmark member, you enjoy many convenient options for where you can receive outpatient care:

- Primary care physician's (PCP) or specialist's office
- Physician's office located in an outpatient hospital/hospital satellite setting
- Urgent Care Center
- Retail site, such as in a pharmacy or other retail store

Different types of providers and their locations may require different payment amounts. The specific amounts you are responsible for paying depend on your particular Highmark benefits.

Therapeutic Injections

Therapeutic injections required in the diagnosis, prevention and treatment of an injury or illness.

Mental Health Care Services

Your mental health is just as important as your physical health. That's why your PPO program provides professional, confidential mental health care that addresses your individual needs. You have access to a wide range of mental health and substance abuse professional providers, so you can get the appropriate level of responsive, confidential care.

You are covered for a full range of counseling and treatment services. The PPO program covers the following services you receive from a provider to treat mental illness:

Inpatient Facility Services

Inpatient hospital services provided by a facility provider for the treatment of mental illness.

Inpatient Medical Services

Covered inpatient medical services provided by a professional provider:

- Individual psychotherapy
- Group psychotherapy
- Psychological testing
- Counseling with family members to assist in your diagnosis and treatment
- Electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same professional provider

Partial Hospitalization Mental Health Care Services

Benefits are only available for mental health care services provided on a partial hospitalization basis when received through a partial hospitalization program. A mental health care service provided on a partial hospitalization basis will be deemed an outpatient care visit and is subject to any outpatient care cost-sharing amounts.

Outpatient Mental Health Care Services

Inpatient facility service and inpatient medical benefits (except room and board) provided by a facility provider or professional provider as described above, are also available when you are an outpatient.

Serious Mental Illness Care Services

Coverage is provided for inpatient care and outpatient care for the treatment of serious mental illness. A serious mental illness service provided on a partial hospitalization basis will be deemed to be an outpatient care visit subject to any outpatient care cost-sharing amounts.

Orthotic Devices

Purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part.

Pediatric Extended Care Services

Benefits are provided for care received from a pediatric extended care facility that is licensed by the state and is primarily engaged in providing basic non-residential services to infants and/or young children who have complex medical needs requiring skilled nursing and therapeutic care and who may be technologically dependent.

Services rendered by a pediatric extended care facility pursuant to a treatment plan for which benefits may include one or more of the following:

- Skilled nursing services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN)
- Physical medicine, speech therapy and occupational therapy
- Respiratory therapy
- Medical and surgical supplies provided by the pediatric extended care facility
- Acute health care support
- Ongoing assessments of health status, growth and development

Pediatric extended care services will be covered for children eight years of age or under, pursuant to the attending physician's treatment plan only when provided in a pediatric extended care facility, and when approved by Highmark.

A prescription from the child's attending physician is necessary for admission to such facility.

No benefits are payable after the child has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care.

Private Duty Nursing Services

Services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered by a physician, providing such nurse does not ordinarily reside in your home or is not a member of your immediate family.

- If you are an inpatient in a facility provider only when Highmark determines that the nursing services required are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff.
- If you are at home only when Highmark determines that the nursing services require the skills of an RN or an LPN.

Prosthetic Appliances

Purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies which replace all or part of an absent body organ and its adjoining tissues, or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). Initial and subsequent prosthetic devices to replace the removed breast(s) or a portion thereof are also covered.

Preventive Care Services

Preventive benefits are offered in accordance with a predefined schedule based on age, sex and certain risk factors. Highmark periodically reviews the schedule of covered services based on recommendations from organizations such as the American Academy of Pediatrics, the American College of Physicians, the U.S. Preventive Services Task Force, the American Cancer Society and the Blue Cross and Blue Shield Association. Therefore, the frequency and eligibility of services is subject to change. Benefits include periodic physical examinations, well child visits, immunizations and selected diagnostic tests. For a current schedule of covered services, log onto the member Web site, www.highmarkbcbs.com, or call Member Service at the toll-free telephone number listed on the back of your ID card.

Adult Care

Routine physical examinations, regardless of medical necessity and appropriateness, including a complete medical history.

Adult Immunizations

Benefits are provided for adult immunizations, including the immunizing agent, when required for the prevention of disease.

Routine Gynecological Examination and Pap Test

All female members, regardless of age, are covered for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year. Benefits are not subject to program deductibles or maximums.

Mammographic Screening

Benefits are provided for the following:

- An annual routine mammographic screening for all female members 40 years of age or older.
- Mammographic examinations for all female members regardless of age when such services are prescribed by a physician.

Benefits for mammographic screening are payable only if performed by a mammography service provider who is properly certified.

Pediatric Care

Routine physical examinations, regardless of medical necessity and appropriateness.

Pediatric Immunizations

Benefits are provided to members under 21 years of age and dependent children for those pediatric immunizations, including the immunizing agents, which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services. Benefits are not subject to the program deductibles or dollar limits.

Allergy Extract/Injections

Benefits are provided for allergy extract and allergy injections.

Colorectal Cancer Screenings

Benefits are provided for the following tests or procedures when ordered by a physician for the purpose of early detection of colorectal cancer:

- Diagnostic laboratory and pathology screening services such as a fecal-occult blood or fecal immunochemical test
- Diagnostic x-ray screening services such as barium enema
- Surgical screening services such as flexible sigmoidoscopy and colonoscopy and hospital services related to such surgical screening services
- Such other diagnostic pathology and laboratory, diagnostic x-ray, surgical screening tests and diagnostic screening services consistent with approved medical standards and practices for the detection of colon cancer

Benefits are provided for members 50 years of age or older as follows, or more frequently and regardless of age when prescribed by a physician:

- An annual fecal-occult blood test or fecal immunochemical test
- A sigmoidoscopy every five years
- A screening barium enema or test consistent with approved medical standards and practices to detect colon cancer every five years