

Pittsburgh Technology Council

CommunityBlue High Option Summary of Benefits

Care is considered coordinated (in-network) when it is performed or referred by your PCP. If you choose to obtain medical care through another physician, this care will be considered self-referred (out-of-network) because it is not coordinated through your PCP. Below are specific benefit levels.

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BENEFIT	COORDINATED CARE (IN - NETWORK)	SELF-REFERRED CARE (OUT - OF - NETWORK)
Deductible		
Individual	None	\$250
Family	None	\$500
Out-of-Pocket Maximums	Not Applicable	\$2,000/Individual \$4,000/Family
Coinsurance	100%	80% after deductible until out-of-pocket maximum is met; then 100%
Policy Maximum	Unlimited	\$1,000,000
Premier Prescription Drug Program (Defined by Premier Gold III Pharmacy Network - Not Physician Network)	Retail Drugs \$10 Co-Pay Generic \$20 Co-Pay Brand Mandatory Generic + Formulary **** 31-day supply	
	Maintenance Drugs through Mail Order \$20 Co-Pay Generic \$40 Co-Pay Brand Mandatory Generic + Formulary **** 90-day Supply	
Physician Office Visits (PCP)	100% after \$10 Co-Pay	80% after deductible
Specialist Office Visits	100% after \$10 Co-Pay	80% after deductible
Preventive Care		
Adult		
Routine physical exams	100% after \$10 Co-Pay	Not Covered
Routine gynecological exams, including pap smears *	100% after \$10 Co-Pay	Self-referred to in-network provider: 100% after \$10 Co-Pay Self-referred to out-of-network provider: 80%; deductible/policy max. does not apply
Mammograms, as required	100%	80% after deductible
Pediatric		
Pediatric immunizations	100%	80%; deductible/policy max. does not apply
Routine physical exams	100% after \$10 Co-Pay	Not Covered
Emergency Room Services	100% after \$35 Co-Pay (waived if admitted)	
	Emergency care is paid at the coordinated benefits level	Self-referred benefits (80% after deductible) apply for non-emergency care
Hospital Expenses		
Inpatient	100%	80% after deductible
Outpatient	100%	80% after deductible
Other Covered Services (Such as Durable Medical Equipment, Ambulance Services, etc.)	100%	80% after deductible
Medical/Surgical Expenses (Except Office Visits)	100%	80% after deductible
Maternity *	100%	Self-referred to in-network provider: 100% Self-referred to out-of-network provider: 80% after deductible
Infertility Counseling, Testing and Treatment **	100%	80% after deductible
Assisted Fertilization Procedures	Not Covered	

Pittsburgh Technology Council CommunityBlue High Option Summary of Benefits (cont'd.)

BENEFIT	COORDINATED CARE (IN - NETWORK)	SELF-REFERRED CARE (OUT - OF - NETWORK)
Physical Therapy	100% after \$10 Co-Pay Combined limit: 20 visits/calendar year	80% after deductible
Speech Therapy	100% after \$10 Co-Pay Combined limit: 20 visits/calendar year	80% after deductible
Occupational Therapy	100% after \$10 Co-Pay Combined limit: 20 visits/calendar year	80% after deductible
Spinal Manipulation	100% after \$10 Co-Pay Combined limit: 20 visits/calendar year	80% after deductible
Diagnostic Services (Lab, X-ray and other tests)	100%	80% after deductible
Skilled Nursing Facility	100%	80% after deductible; Limit: 100 days/calendar year
Home Health Care	100%	80% after deductible
Private Duty Nursing	100%	80% after deductible
Hospice	100%	80% after deductible
Mental Health*****		
Inpatient	100% Limit: 30 days/calendar year	80% after deductible Limit: 10 days/calendar year
	Combined Limit: 30 days/calendar year	
Outpatient	100% after \$10 Co-Pay Limit: 20 visits/calendar year	80% after deductible Limit: 10 visits/calendar year
	Combined Limit: 20 visits/calendar year	
Substance Abuse*****		
Inpatient Detoxification	100% 7 days/admission; 4 admissions/lifetime	80% after deductible
Rehabilitation	100% 30 days/year; 90 days/lifetime	80% after deductible
Outpatient	100% after \$10 Co-Pay 60 visits/year; 120 visits/lifetime	80% after deductible
Precertification Requirements	Performed by Network Medical Management	Required for inpatient admission to non-Community Blue network hospital ***
Claim Forms Required	No	Yes

* A female member may *self-refer* to a Community Blue network OB/GYN of her choice for any gynecological or maternity care. These services do not require authorization or a referral from your PCP.

** 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.

*** If Blue Cross Blue Shield is not contacted prior to a non-emergency inpatient admission 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.

**** Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. Under the mandatory generic provision, the member is responsible for the payment differential when a generic drug is available and the **doctor or patient** specifies a brand name drug. The member payment is the price difference between the brand drug and the generic drug in addition to the brand drug Co-Pay or coinsurance amounts which may apply.

***** To obtain mental health and substance abuse services at maximum benefits level, you must contact Highmark's Mental Health and Substance Abuse unit before seeking treatment.

Note: The shaded areas on this benefit summary grid indicate benefit changes for the 2004 plan year.