HIGHMARK. ClassicBlue. Traditional Programs

Summary of ClassicBlue Traditional *Benefits*

Under the Traditional benefits program, health care benefits are provided separated into hospital benefits, medical/surgical benefits and Major Medical benefits. These benefits include coverage for hospital services, physician services, and many other covered services. Most Major Medical benefits are subject to deductible and coinsurance provisions, which require you to share a portion of the medical costs. Below are specific benefit levels.

Pittsburgh Technology Council

Benefit	Hospital	Medical/Surgical	Major Medical
Benefit Period ①	Calendar Year		
Deductible (per benefit period)			
Individual	None	None	$200
Family	None	None	$400
Plan Payment Level – Based on the provider's reasonable charge (PRC)	100%	100%	80% after deductible until out-of-pocket maximum is met; then 100%
Out-of-Pocket Maximums			
Individual	Not Applicable	Not Applicable	$400
Family	Not Applicable	Not Applicable	$800
Lifetime Maximum (per person)	Unlimited	Unlimited	$1,000,000
Primary Care Physician Office Visits	Not Covered	Not Covered	80% after deductible
Specialist Office Visits	Not Covered	Not Covered	80% after deductible
Preventive Care			
Adult			
Routine physical exams	Not Covered	Not Covered	Not Covered
Adult Immunizations	Not Covered	Not Covered	80% (deductible does not apply)
Routine gynecological exams, including a PAP Test	100%	100%	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	100%	80% after deductible
Pediatric			
Routine physical exams	Not Covered	Not Covered	Not Covered
Pediatric immunizations	100%	100%	80% (deductible does not apply)
Emergency Room Services	100%	100%	80% after deductible
Spinal Manipulations	Not Applicable	Not Covered	80% after deductible Limit: 20 visits/benefit period
Physical Medicine	100% Limit: 21 visits/benefit period	Not Covered	80% after deductible Limit: 20 visits/benefit period
Speech Therapy	100% Limit: 21 visits/benefit period	Not Covered	80% after deductible Limit: 20 visits/benefit period
Occupational Therapy	100% Limit: 21 visits/benefit period	Not Covered	80% after deductible Limit: 20 visits/benefit period
Allergy Extracts and Injections	Not Covered	Not Covered	80% after deductible
Ambulance	Not Covered	Not Covered	80% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered	Not Covered
Dental Services Related to Accidental Injury	100%	Not Covered	Not Covered
Diabetes Treatment	100%	Not Covered	80% after deductible
Diagnostic Services (including routine) ***Advanced Imaging*** (MRI, CAT Scan, PET scan, etc.)	100%	100%	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	Not Covered	Not Covered	80% after deductible
Enteral Formulae	Not Covered	Not Covered	80% (deductible does not apply)
Home Infusion Therapy	Not Covered	Not Covered	80% after deductible

<table>
<tr><th>Benefit</th><th>Hospital</th><th>Medical/Surgical</th><th>Major Medical</th></tr>
<tr><td>Home Health Care</td><td>100%
Limit: 100 visits/benefit period</td><td>Not Applicable</td><td>80% after deductible</td></tr>
<tr><td>Hospice</td><td>Not Covered</td><td>Not Applicable</td><td>80% after deductible</td></tr>
<tr><td>Hospital Services – Inpatient</td><td>100%</td><td>Not Applicable</td><td>80% after deductible</td></tr>
<tr><td>Hospital Services – Outpatient</td><td>100%</td><td>Not Applicable</td><td>80% after deductible</td></tr>
<tr><td>Infertility Counseling, Testing and Treatment②</td><td>100%</td><td>100%</td><td>80% after deductible</td></tr>
<tr><td>Maternity (facility & professional services)</td><td>100%</td><td>100%</td><td>80% after deductible</td></tr>
<tr><td>Medical/Surgical Expenses
(Except Office Visits)</td><td>Not Applicable</td><td>100%</td><td>80% after deductible</td></tr>
<tr><td>Mental Health – Inpatient③</td><td>100%
Limit: 30 days/benefit period</td><td>100%
Limit: 30 days/benefit period</td><td>80% after deductible</td></tr>
<tr><td>Mental Health – Outpatient③</td><td>Not Covered</td><td>Not Covered</td><td>50% after deductible</td></tr>
<tr><td>Private Duty Nursing</td><td>Not Covered</td><td>Not Applicable</td><td>80% after deductible</td></tr>
<tr><td>Respiratory Therapy</td><td>100%</td><td>Not Covered</td><td>80% after deductible
Limit: 20 visits/benefit period</td></tr>
<tr><td>Skilled Nursing Facility Care</td><td>100%</td><td>Not Covered</td><td>80% after deductible</td></tr>
<tr><td rowspan="2">Substance Abuse – Detoxification</td><td>100%</td><td>100%</td><td rowspan="2">80% after deductible</td></tr>
<tr><td colspan="2">Limit: 7 days/admission; 4 admissions/lifetime</td></tr>
<tr><td rowspan="2">Substance Abuse – Rehabilitation</td><td>100%</td><td>100%</td><td rowspan="2">80% after deductible</td></tr>
<tr><td colspan="2">Limit: 30 days/benefit period; 90 days/lifetime</td></tr>
<tr><td rowspan="2">Substance Abuse – Outpatient</td><td>100%</td><td>Not Covered</td><td rowspan="2">50% after deductible</td></tr>
<tr><td colspan="2">Limit: 60 visits/benefit period; 120 visits/lifetime</td></tr>
<tr><td>Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)</td><td>100%
(Cardiac Rehab: Not Covered)</td><td>100% (Cardiac Rehab & Infusion Therapy: Not Covered)</td><td>80% after deductible</td></tr>
<tr><td>Transplant Services</td><td>100%</td><td>100%</td><td>80% after deductible</td></tr>
<tr><td>Precertification Requirements</td><td>Performed by Member④</td><td>Performed by Member④</td><td>Performed by Member④</td></tr>
<tr><td>Prescription Drug Deductible
Individual
Family</td><td colspan="3">Per benefit period
None
None</td></tr>
<tr><td>Premier Prescription Drug Program</td><td colspan="3">Defined by Premier Gold Pharmacy Network - Not Physician Network.
(Prescriptions filled at a non-network pharmacy are not covered.)

80% after deductible</td></tr>
</table>

① Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

② 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.

③ State mandated benefits (30 inpatient days and 60 outpatient visits annually with the right to exchange inpatient days for outpatient visits on a one-for-two basis) may 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, delusional disorder. Once mental health limits are exhausted, both inpatient and outpatient serious mental illness services must be provided by a network provider (see above-referenced benefits for plan limits).

④ Member is required to contact Highmark Health Care Management Services prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related admission. 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.

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.