

PCI Insurance, Inc.
PPO1 Benefit Summary – effective Jan. 1, 2007

If you receive services in the Plan Service Area from a Network Provider or in the Highmark Managed Care Network Service Area from a Preferred Professional Provider, Participating Facility Provider or Contracting Supplier, you will receive the highest level of benefits. If you choose to obtain medical care through another provider or a provider outside of the Plan Service Area or outside the Highmark Managed Care Network Service Area, you will receive the lower level of benefits. There is no need to select a Primary Care Physician (PCP). No referrals are needed for specialty care.

BENEFITS	PPO Option 1	
	IN-NETWORK	OUT-OF-NETWORK
Benefit Period	Contract Year <i>Twelve consecutive months beginning on the contract date</i>	
Deductible Per Benefit Period	None	\$250 Individual \$500 Family Aggregate
Payment Level <i>Based on Provider's Reasonable Charge (PRC)</i>	100% PRC	80% PRC after deductible until out-of-pocket limit is met; then 100% PRC
Out-of-Pocket Limit <i>Includes Coinsurance, certain exclusions may apply</i>	Not Applicable	\$3,000 Individual \$6,000 Family Aggregate
Lifetime Maximum	Unlimited	
Ambulance	100% PRC	80% PRC after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to an Accidental Injury	Not Covered	Not Covered
Diabetes Treatment	100% PRC	80% PRC after deductible
Diagnostic Services Lab, X-ray, and Medical Tests	100% PRC	80% PRC after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% PRC	80% PRC after deductible
Emergency Room Services	100% PRC after \$35 copay – waived if admitted	
Enteral Formulae	100% PRC	80% PRC no deductible
Hearing Care Services	Not Covered	Not Covered
Home Health Care <i>Excludes Respite Care</i>	100% PRC	80% PRC after deductible
Hospice <i>Includes Respite Care</i>	100% PRC	80% PRC after deductible
Hospital Expenses <i>Inpatient and Outpatient</i>	100% PRC	80% PRC after deductible
	0 pint blood deductible/benefit period	
Infertility Counseling, Testing and Treatment <i>Treatment includes coverage for the correction of a physical or medical problem associated with infertility.</i>	100% PRC	80% PRC after deductible
Maternity Includes Dependent Daughters	100% PRC	80% PRC after deductible
Medical Care <i>Includes Inpatient Visits and Consultations</i>	100% PRC	80% PRC after deductible
Mental Health Inpatient Ⓣ <i>Includes Partial Hospitalization (2 for 1 trade)</i>	100% PRC	80% PRC after deductible
Mental Health Outpatient Ⓣ	100% PRC after \$15 Copay	50% PRC after deductible
	30 days/benefit period (up to 30 for serious mental illness) 30 visits/benefit period (up to 60 for serious mental illness)	
Office Visits <i>Primary Care Physician</i> <i>Specialty Care Physician</i>	100% PRC after \$15 Copay 100% PRC after \$15 Copay	80% PRC after deductible 80% PRC after deductible
Oral Surgery	100% PRC	80% PRC after deductible
Physical Medicine Outpatient	100% PRC after \$15 Copay	80% PRC after deductible
	20 visits/benefit period	

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 (Continued)

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	IN-NETWORK	OUT-OF-NETWORK
Preventive Care		
<i>Adult Preventive Care Schedule includes:</i>		
<i>Routine Physical Exam</i>	100% PRC after \$15 Copay	80% PRC after deductible
<i>Immunizations</i>	100% PRC	80% PRC after deductible
<i>Routine Diagnostic Screening</i>	100% PRC	80% PRC after deductible
<i>Screening, Mammography</i>	100% PRC	80% PRC after deductible
<i>Routine Gynecological Exam & Pap Test</i>	100% PRC after \$15 Copay	80% PRC no deductible
<i>Pediatric Preventive Care Schedule includes:</i>		
<i>Routine Physical Exams</i>	100% PRC after \$15 Copay	80% PRC after deductible
<i>Pediatric Immunizations</i>	100% PRC	80% PRC no deductible
<i>Routine Diagnostic Screening</i>	100% PRC	80% PRC after deductible
Private Duty Nursing	100% PRC	80% PRC after deductible
	----- 240 hours/benefit period	
Skilled Nursing Facility Care	100% PRC	80% PRC after deductible
	----- 100 days/benefit period	
Speech & Occupational Therapy <i>Outpatient</i>	100% PRC after \$15 Copay	80% PRC after deductible
	----- 12 visits/benefit period per type of therapy	
Spinal Manipulations	100% PRC after \$15 Copay	80% PRC after deductible
	----- 20 visits/benefit period	
Substance Abuse Detoxification	100% PRC	80% PRC after deductible
	----- 7 days/admission; 4 admissions/lifetime	
Substance Abuse Inpatient Rehabilitation <i>Includes Partial Hospitalization (2 for 1 trade)</i>	100% PRC	80% PRC after deductible
	----- 30 days/benefit period; 90 days/lifetime	
Substance Abuse Outpatient	100% PRC after \$15 Copay	80% PRC after deductible
	----- 60 visits/benefit period; 120 visits/lifetime	
Surgical Expenses <i>Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, Excludes Neonatal Circumcision</i>	100% PRC	80% PRC after deductible
Therapy and Rehabilitation Services <i>Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy</i>	100% PRC	80% PRC after deductible
Transplant Services	100% PRC	80% PRC after deductible
Precertification Requirements for Inpatient Admissions <i>No Penalty for Non-compliance. If Highmark Blue Shield is not contacted prior to a non-emergency out-of-network inpatient admission and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the member will be responsible for any costs not covered.</i>	Performed by Network Provider	Performed by Member
Condition Management	Case Management, Blues on Call, and Disease State Management	

Ⓢ State mandated benefits (30 inpatient days and 60 outpatient visits annually) **may** apply for serious diagnosis. Serious diagnosis includes schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder.

Benefits change from Calendar Year to Contract Year with the exception of Annual Limits on Routine Services.