

## *PCI Insurance, Inc.* *PPO3 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.

| <b>BENEFITS</b>   | <b>PPO Option 3</b>  |  |
|---|--|--|
|   | <b>IN-NETWORK</b>  | <b>OUT-OF-NETWORK</b>  |
| <b>Benefit Period</b>   | Contract Year  |  |
|   | <i>Twelve consecutive months beginning on the contract date</i>          |  |
| <b>Deductible Per Benefit Period</b>  | \$400 Individual<br>\$800 Family Aggregate                               | \$800 Individual<br>\$1,600 Family Aggregate                             |
| <b>Payment Level</b><br><i>Based on Provider's Reasonable Charge (PRC)</i>  | 90% PRC after deductible until out-of-pocket limit is met; then 100% PRC | 70% PRC after deductible until out-of-pocket limit is met; then 100% PRC |
| <b>Out-of-Pocket Limit</b><br><i>Includes Coinsurance, certain exclusions may apply</i>   | \$1,000 Individual<br>\$2,000 Family Aggregate                           | \$3,000 Individual<br>\$6,000 Family Aggregate                           |
| <b>Lifetime Maximum</b>   | Unlimited  |  |
| <b>Ambulance</b>  | 90% PRC after deductible   | 70% PRC after deductible   |
| <b>Assisted Fertilization Procedures</b>  | Not Covered  |  |
| <b>Dental Services Related to an Accidental Injury</b>  | Not Covered  |  |
| <b>Diabetes Treatment</b>   | 90% PRC after deductible   | 70% PRC after deductible   |
| <b>Diagnostic Services Lab, X-ray, and Medical Tests</b>  | 90% PRC after deductible   | 70% PRC after deductible   |
| <b>Durable Medical Equipment, Orthotics and Prosthetics</b>   | 90% PRC after deductible   | 70% PRC after deductible   |
| <b>Emergency Room Services</b>  | 100% PRC after \$50 copay – waived if admitted                           |  |
| <b>Enteral Formulae</b>   | 90% PRC no deductible  | 70% PRC no deductible  |
| <b>Hearing Care Services</b>  | Not Covered  |  |
| <b>Home Health Care</b><br><i>Excludes Respite Care</i>   | 90% PRC after deductible   | 70% PRC after deductible   |
|   | 90 visits/benefit period   |  |
| <b>Hospice</b><br><i>Includes Respite Care</i>  | 90% PRC after deductible   | 70% PRC after deductible   |
| <b>Hospital Expenses</b><br><i>Inpatient and Outpatient</i>   | 90% PRC after deductible   | 70% PRC after deductible   |
|   | 0 pint blood deductible/benefit period                                   |  |
| <b>Infertility Counseling, Testing and Treatment</b><br><i>Treatment includes coverage for the correction of a physical or medical problem associated with infertility.</i> | 90% PRC after deductible   | 70% PRC after deductible   |
| <b>Maternity Includes Dependent Daughters</b>   | 90% PRC after deductible   | 70% PRC after deductible   |
| <b>Medical Care</b><br><i>Includes Inpatient Visits and Consultations</i>   | 90% PRC after deductible   | 70% PRC after deductible   |
| <b>Mental Health Inpatient</b> Ⓣ<br><i>Includes Partial Hospitalization (2 for 1 trade)</i>   | 90% PRC after deductible   | 70% PRC after deductible   |
|   | 30 days/benefit period (up to 30 for serious mental illness)             |  |
| <b>Mental Health Outpatient</b> Ⓣ   | 100% PRC after \$25 Copay  | 50% PRC after deductible   |
|   | 30 visits/benefit period (up to 60 for serious mental illness)           |  |
| <b>Office Visits</b><br><i>Primary Care Physician</i><br><i>Specialty Care Physician</i>  | 100% PRC after \$25 Copay<br>100% PRC after \$25 Copay                   | 70% PRC after deductible<br>70% PRC after deductible                     |
| <b>Oral Surgery</b>   | 90% PRC after deductible   | 70% PRC after deductible   |
| <b>Physical Medicine Outpatient</b>   | 100% PRC after \$25 Copay  | 70% PRC after deductible   |
|   | 20 visits/benefit period   |  |

**PCI Insurance, Inc.**  
**PPO3 Benefit Summary – effective Jan. 1, 2007**  
 (Continued)

| BENEFITS  | PPO Option 3   |                          |
|---|--|--------------------------|
|   | IN-NETWORK   | OUT-OF-NETWORK           |
| <b>Preventive Care</b>  |  |                          |
| <i>Adult Preventive Care Schedule includes:</i>   |  |                          |
| <i>Routine Physical Exam</i>  | 100% PRC after \$25 Copay                                    | 70% PRC after deductible |
| <i>Immunizations</i>  | 90% PRC after deductible                                     | 70% PRC after deductible |
| <i>Routine Diagnostic Screening</i>   | 90% PRC after deductible                                     | 70% PRC after deductible |
| <i>Screening, Mammography</i>   | 90% PRC no deductible  | 70% PRC after deductible |
| <i>Routine Gynecological Exam &amp; Pap Test</i>  | 100% PRC after \$25 Copay                                    | 70% PRC no deductible    |
| <i>Pediatric Preventive Care Schedule includes:</i>   |  |                          |
| <i>Routine Physical Exams</i>   | 100% PRC after \$25 Copay                                    | 70% PRC after deductible |
| <i>Pediatric Immunizations</i>  | 90% PRC no deductible  | 70% PRC no deductible    |
| <i>Routine Diagnostic Screening</i>   | 90% PRC after deductible                                     | 70% PRC after deductible |
| <b>Private Duty Nursing</b>   | 90% PRC after deductible                                     | 70% PRC after deductible |
|   | 240 hours/benefit period                                     |                          |
| <b>Skilled Nursing Facility Care</b>  | 90% PRC after deductible                                     | 70% PRC after deductible |
|   | 100 days/benefit period                                      |                          |
| <b>Speech &amp; Occupational Therapy<br/>Outpatient</b>   | 100% PRC after \$25 Copay                                    | 70% PRC after deductible |
|   | 12 visits/benefit period per type of therapy                 |                          |
| <b>Spinal Manipulations</b>   | 100% PRC after \$25 Copay                                    | 70% PRC after deductible |
|   | 20 visits/benefit period                                     |                          |
| <b>Substance Abuse Detoxification</b>   | 90% PRC after deductible                                     | 70% PRC after deductible |
|   | 7 days/admission; 4 admissions/lifetime                      |                          |
| <b>Substance Abuse Inpatient Rehabilitation</b><br><i>Includes Partial Hospitalization (2 for 1 trade)</i>  | 90% PRC after deductible                                     | 70% PRC after deductible |
|   | 30 days/benefit period; 90 days/lifetime                     |                          |
| <b>Substance Abuse Outpatient</b>   | 100% PRC after \$25 Copay                                    | 70% PRC after deductible |
|   | 60 visits/benefit period; 120 visits/lifetime                |                          |
| <b>Surgical Expenses</b><br><i>Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, Excludes Neonatal Circumcision</i>  | 90% PRC after deductible                                     | 70% PRC after deductible |
| <b>Therapy and Rehabilitation Services</b><br><i>Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy</i>   | 90% PRC after deductible                                     | 70% PRC after deductible |
| <b>Transplant Services</b>  | 90% PRC after deductible                                     | 70% PRC after deductible |
| <b>Precertification Requirements for Inpatient Admissions</b><br><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      |
| <b>Condition Management</b>   | 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.