Summary of PPO *Benefits (Basic and Premium Plans)*

A PPO, or Preferred Provider Organization, offers two levels of benefits. If you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels.

Summary of PPO High Deductible Health Plan *Benefits*

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. **If you enroll as an individual, the deductible and out-of-pocket maximums for the "Employee Only Plan" apply. For family coverage, the annual deductible is $7,000 per calendar year for all covered persons in the family. No one in the family is eligible for benefits until the family deductible has been satisfied.**

NOTE: By Federal Regulation, Medicare Primary members are not eligible to participate in the High Deductible Health Plan (HDHP)

Evangelical Presbyterian Church

	Effective 1-1-12					
Benefits	**PPO**					
	Basic Option 1		**Premium Option 2**		**High Deductible Health Plan (HDHP) Option 3**	
	Network	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
Benefit Period①	Calendar Year		Calendar Year		Calendar Year	
Deductible Employee Employee + 1 dependent Family	 $780 $1,560 $2,340	 $1,560 $3,120 $4,680	 $390 $780 $1,170	 $780 $1,560 $2,340	 $3,500 ② $7,000 combined ② $7,000 combined ②	
Plan Payment Level – Based on the provider's reasonable charge (PRC)	80% after deductible until out-of-pocket is met; then 100%	60% after deductible until out-of-pocket is met; then 100%	90% after deductible until out-of-pocket is met; then 100%	60% after deductible until out-of-pocket is met; then 100%	90% after deductible until out -of - pocket is met, then 100%	80% after deductible until out-of-pocket is met; then 100%
Out-of-Pocket Maximums Employee Employee + 1 dependent Family	 $3,380 $6,760 $10,140	 $6,760 $13,520 $20,280	 $1,690 $2,535 $3,380	 $3,380 $5,070 $6,760	 $1,400 $2,800 $2,800	 $2,800 $5,600 $5,600
Lifetime Maximum	N/A		N/A		N/A	
Primary Physician Office Visits	100% after $20 copayment/visit*	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Specialist Office Visits	100% after $30 copayment/visit*	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible

Benefits	Basic		Premium		HDHP	
Preventive Care ***Adult*** Routine physical exams Including preventative labs and x-rays, blood cholesterol testing, urinalysis, complete blood count and EKG	100%*		100%*		100%*	
Adult immunizations	100%*		100%*		100%*	
Routine gynecological exams, including a PAP Test	100%*		100%*		100%*	
Mammograms	100%*		100%*		100%*	
Colonoscopy and related services	100%*		100%*		100%*	
Pediatric Routine exams Including preventative labs and x-rays, applicable through age 18	100%*		100%*		100%*	
Pediatric immunizations	100%*		100%*		100%*	
Wellness Benefits	Yes **		Yes**		Yes**	
Emergency Room Services	80% after $125 copayment		90%*		90% after deductible	
Allergy Extracts and Injections	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Ambulance	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Hospital Expenses ③ Inpatient	80% after deductible $250 copay/confinement	60% after deductible $250 copay/confinement	90% after deductible	60% after deductible	90% after deductible	80% after deductible
	Limit: 365 days***		Limit: 365 days***		Limit: 365 days***	
Outpatient	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Maternity*(facility and professional services)*	80% after deductible $250 copay/confinement	60% after deductible $250 copay/confinement	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Infertility counseling, testing and treatment ④	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
	$5,000 lifetime maximum		$5,000 lifetime maximum		$5,000 lifetime maximum	

Benefits	Basic		Premium		HDHP	
Assisted Fertilization Procedures	Not Covered		Not Covered		Not covered	Not covered
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Diabetes Treatment	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Medical/Surgical Expenses *(except office visits)*	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Spinal Manipulations	50% after deductible $750 calendar year maximum		50% after deductible $750 calendar year maximum		50% after deductible $750 calendar year maximum	
Diagnostic Services ***Basic*** (Lab, X-Ray and other tests)	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Advanced Imaging (MRI, CAT Scan, PET Scan, etc.)	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Physical Medicine	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Speech Therapy	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Occupational Therapy	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Home Infusion Therapy	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Skilled Nursing Facility Care	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
	Limit:60 days/benefit period; and $250 copay/confinement		Limit 60 days/benefit period;	Limit 60 days/benefit period;	Limit 60 days/benefit period,	Limit: 60 days/benefit period
Home Health Care	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
	Limit: 60 days/benefit period		Limit: 60 days/benefit period		Limit: 60 days/benefit period	
Private Duty Nursing	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Respiratory Therapy	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Hospice	100%*		100%*		90% *	

Benefits	Basic		Premium		HDHP	
Mental Health Inpatient	80% after deductible $250 copay/confinement	60% after deductible $250 copay/confinement	90% after deductible	60% after deductible	90% after deductible	80% after deductible
	Limit: 365 days/benefit period***		Limit: 365 days/benefit period***		Limit: 365 days/benefit period***	
Outpatient, includes family and marriage counseling	100% after $30 copayment/visit*	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Substance Abuse *Inpatient* Detoxification	80% after deductible $250 copay/confinement	60% after deductible $250 copay/confinement	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Rehabilitation	80% after deductible $250 copay/confinement	60% after deductible $250 copay/confinement	90% after deductible	60% after deductible	90% after deductible	80% after deductible
	Limit 365 days/benefit period***		Limit 365 days/benefit period***		Limit 365 days/benefit period***	
Outpatient	100% after $30 copayment/visit*	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Therapy Services (Cardiac Rehab, Chemotherapy, Radiation Therapy, Dialysis)	80% after deductible	60% after deductible	90% after deductible	60% after deductible	90% after deductible	80% after deductible
Transplant Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	80% after deductible
Precertification Requirements	Performed by Member③ $150 penalty for failure to precertify		Performed by Member③ $150 penalty for failure to precertify		Performed by Member③ $150 penalty for failure to precertify	
Prescription Drug Program	**Administered thru Express Scripts** **Retail Drugs:** Co-payment Generic $9 Co-payment, Formulary Brand $35 Co-payment, Non-Formulary Brand $58 **Mail Order Drugs:** **90 day supply** Co-payment Generic $18 Co-payment, Formulary Brand $70 Co-payment, Non-Formulary Brand $116 **Note: Specialty drugs-Mail only** $120 per fill		**Administered thru Express Scripts** **Retail Drugs:** Co-payment Generic $9 Co-payment, Formulary Brand $35 Co-payment, Non-Formulary Brand $58 **Mail Order Drugs:** **90 day supply** Co-payment Generic $18 Co-payment, Formulary Brand $70 Co-payment, Non-Formulary Brand $116 **Note: Specialty drugs- Mail only** $120 per fill		Defined by Premier National Pharmacy Network – Not Physician Network (Prescriptions filled at a non-network pharmacy are not covered) Medical deductible applies **Retail Drugs:** Plan pays 90% after deductible 31-day supply **Maintenance Drugs Through Mail Order:** Plan pays 90% after deductible 90-day supply	

* Deductible does not apply
** Please visit Highmark's website at www HighmarkBCBS.com to learn more about your options for wellness benefits on the website.
***Medical and Mental Health/Substance Abuse days have a combined 365 day limit

Questions? Call 1-800-215-7865

Reference Code: P0090707

(Please have your Reference Code ready when you call)

① Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
② Churches that enroll an individual in the High Deductible Health Plan are required to make payment to the individual's Health Savings Account as follows:
  a) Individual – 50% of the $3,500 Annual Deductible payable monthly at $145.83
  b) All other categories – 50% of the $7,0000 Annual Deductible payable monthly at $291.67
③ 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.
④ 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.