State System of Higher Education
*PPOBlue Benefit Summary**

Effective July 1, 2004

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 need to select a Primary Care Physician (PCP). No referrals are needed for specialty care. Below are specific benefit levels.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Deductible *Per Calendar Year*	None	$250 Individual $500 Family Aggregate
Payment Level *Based on Provider's Reasonable Charge* (PRC)	100% PRC	80% PRC after deductible until out-of-pocket limit is met; then 100% PRC
Out-of-Pocket Limit *Includes Coinsurance*	Not Applicable	$1,500 Individual $3,000 Family Aggregate
Lifetime Maximum	Unlimited	$1,000,000/person
Ambulance	100% PRC	80% PRC after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to an Accidental Injury	100% PRC	80% PRC after deductible
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
Elective Abortion	Not Covered (except in cases of rape, incest, or to avert death of the mother)	Not Covered (except in cases of rape, incest, or to avert death of the mother)
Emergency Care *Professional Services*	100% PRC	100% PRC no deductible
Emergency Room Services *Facility Services*	100% PRC after $50 copayment – waived if admitted	
Enteral Formulae	100% PRC	80% PRC no deductible
Home Health Care *Excludes Respite Care*	100% PRC 60 visits/calendar year	80% PRC after deductible
Hospice *Includes Respite Care*	100% PRC 180 days/lifetime maximum	80% PRC after deductible
Hospital Expenses *Inpatient and Outpatient*	100% PRC 365 days 2 pint blood deductible/calendar year	80% PRC after deductible
Infertility Counseling, Testing and Treatment	100% PRC	80% PRC after deductible
Maternity *Excludes Dependent Daughters*	100% PRC	80% PRC after deductible
Medical Care *Includes Inpatient Visits and Consultations*	100% PRC	80% PRC after deductible
Mental Health – Inpatient * *Includes Partial Hospitalization (2 for 1 trade)*	100% PRC 30 days/calendar year	80% PRC after deductible
Mental Health – Outpatient	100% PRC after $15 copayment 60 visits/calendar year	50% PRC after deductible
Office Visits *PCP and Specialists*	100% PRC after $15 copayment	80% PRC after deductible
Oral Surgery	100% PRC	80% PRC after deductible

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March 24, 2004
Final PPO and RX Benefit Summaries and Exclusions

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Physical Therapy *Outpatient*	100% PRC after $15 copayment Unlimited	80% PRC after deductible
Preventive Care *Routine Adult Services include:* *Physical Exam* *Gynecological Exam & Pap Test* *Mammograms* *Preventive Care 2000 Schedule*	 100% PRC after $15 copayment 100% PRC after $15 copayment 100% PRC 100% PRC	 80% PRC after deductible 80% PRC no deductible/lifetime maximum 80% PRC after deductible 80% PRC after deductible
Routine Pediatric Services include: *Physical Exams* *Pediatric Immunizations* *Preventive Care 2000 Schedule*	 100% PRC after $15 copayment 100% PRC 100% PRC	 80% PRC after deductible 80% PRC no deductible/lifetime maximum 80% PRC after deductible
Private Duty Nursing	100% PRC 240 hours/calendar year	80% PRC after deductible
Skilled Nursing Facility Care	100% PRC 100 days/calendar year	80% PRC after deductible
Speech & Occupational Therapy *Outpatient*	100% PRC after $15 copayment 30 visits/calendar year per type of therapy	80% PRC after deductible
Spinal Manipulations	100% PRC after $15 copayment 30 visits/calendar year	80% PRC after deductible
Substance Abuse - Detoxification	100% PRC 7 days/admission; 4 admissions/lifetime	80% PRC after deductible
Substance Abuse – Inpatient Rehabilitation *Includes Partial Hospitalization (2 for 1 trade)*	100% PRC 30 days/calendar year; 90 days/lifetime	80% PRC after deductible
Substance Abuse - Outpatient	100% PRC after $15 copayment 60 visits/calendar year; 120 visits/lifetime	80% PRC after deductible
Surgical Expenses *Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, Excludes Neonatal Circumcision*	100% PRC	80% PRC after deductible
Therapy Services *Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy*	100% PRC	80% PRC after deductible
Transplant Services	100% PRC	80% PRC after deductible
Precertification Requirements for Inpatient Admissions *No Penalty for Non-compliance*	Performed by Network Provider	Performed by Member
Condition Management	Case Management, Blues on Call, and Disease State Management	

Customized

**** This program applies to all active employees and annuitants under the age of 65 retired on or after July 1, 2004***

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State System of Higher Education
Preventive Care 2000

Preventive Care 2000 enhances your benefit package by providing coverage for adult and pediatric preventive care. These preventive measures may help members avoid some diseases and conditions, or detect them early when they can be treated more effectively. Please refer to your benefit booklet for any applicable cost sharing features.

Pediatric Care (Birth through age 17)		
Periodic Physical Exam	**0 to 1 month 2 to 3 months 4 to 5 months 6 to 8 months 9 to 11 months 12 to 14 months (One exam at each age range unless otherwise indicated)**	**15 to 17 months 18 to 24 months 2 to 5 years (annually) 6 to 7 years 8 to 9 years 10 to 17 years (annually)**
Urinalysis	**Birth – 6 years 11 – 17 years**	**(one test during each age range)**
Hemoglobin or Hematocrit	**Birth – 12 months 1 – 4 years 5 – 12 years 13-17 years**	**(one test during each age range)**
Rubella Titer Test	**11 – 17 years**	**(one per lifetime)**
Tuberculosis (TB) Test	**4 – 7 years 13-15 years**	**(one test during each age range)**
Childhood Immunizations (Childhood immunizations such as the following, as required by Pennsylvania state law)	**Diphtheria, Tetanus Pertussis (DTP) Measles, Mumps & Rubella Meningitis**	**Polio Hepatitis B Hemophilus (Hib) Varicella (Chicken Pox)**
Adult Care (Ages 18 and over)		
Periodic Physical Exam	**18 - 49 years 50 years and older**	**(once every three years) (one exam every year)**
Fecal Occult Blood Test	**50 years and older**	**(one test every year)**
Blood Cholesterol Test	**18 – 49 years 50 years and older**	**(one test every three years) (one test every year)**
Adult Tetanus and Diphtheria Toxoid (Td)	**18 years and older**	**(once every 10 years)**
Rubella Titer Test and Immunization	**18 – 49 years**	**(once per lifetime)**
Influenza Vaccine	**50 years and older**	**(once every year)**
Pneumococcal Vaccine	**65 years and older**	**(once every five years)**
Urinalysis	**18 – 49 years 50 years and older**	**(once every three years) (one test every year)**
Complete Blood Count (CBC)	**18 – 49 years 50 years and older**	**(once every three years) (one test every year)**
Flexible Sigmoidoscopy	**50 years and older**	**(one test every year)**
Prostatic Specific Antigen (PSA)	**50 years and older**	**(one test every year)**
Screening Mammography (As required by Pennsylvania state law)	**40 years and older**	**(one test every year)**
Routine Gynecological Exam and Pap Test (As required by Pennsylvania state law)	**No age limit**	**(one exam and test every year)**

HIGHMARK. PPOBlue A Preferred-Provider Program

Health Benefit Exclusions

Below is a list of services that are typically excluded from coverage unless they are specifically added to the final contract. As exclusion, no benefits will be provided for services, supplies or charges:

1. Which are not medically necessary and appropriate as determined by the plan;
2. Which are not prescribed by or performed by or upon the direction of a professional provider;
3. Rendered by other than providers;
4. Which are experimental/investigative in nature;
5. Rendered prior to the member's effective date;
6. Incurred after the date of termination of the member's coverage;
7. For any illness or injury suffered after the member's effective date as a result of any act of war;
8. For which a member would have no legal obligation to pay;
9. Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
10. To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer the member all the benefits and the member so elects this coverage as primary;
11. For any amounts the member is required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare complementary program;
12. For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease, or similar type legislation. This exclusion applies whether or not the member files a claim for said benefits or compensation;
13. To the extent benefits are provided to members of the armed forces and the National Health Service or to patients in Veteran's Administration facilities for service-connected illness or injury, unless the member has a legal obligation to pay;
14. For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act;
15. For prescription drugs and medications, except those which are administered to an inpatient in a facility provider;
16. Which are submitted by a certified registered nurse and another professional provider or other provider for the same services performed on the same date for the same member;
17. Rendered by a provider who is a member of the member's immediate family;
18. Performed by a professional provider or other provider enrolled in an education or training program when such services are related to the education or training program;

19. For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise required by law or provider. Other exceptions to this exclusion are: a) Surgery to correct a condition resulting from an accident; b) Surgery to correct congenital birth defects; and c) Surgery to correct functional impairment which results from a covered disease or injury;
20. For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
21. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier-free" home modifications, whether or not specifically recommended by a professional provider or other provider;
22. For inpatient admissions which are primarily for diagnostic studies;
23. For inpatient admissions which are primarily for physical therapy;
24. For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care;
25. Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates;
26. For oral surgery procedures, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, unless specifically provided;
27. For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;
28. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
29. For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids, unless specifically provided;
30. For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery;
31. For artificial insemination;
32. Related to treatment provided specifically for the purpose of assisted fertilization; including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law;
33. For routine neonatal circumcision;
34. For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, (except for aphakic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);
35. For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related Services;

36. For treatment of obesity, except for medical and surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height and sex;
37. For nutritional counseling and services intended to produce weight loss;
38. For any food including, but not limited to, enteral formulae, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis. This does not include enteral formulae prescribed solely for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria;
39. For preventive care services, wellness services or programs, except as provided in the final contract or as mandated by law;
40. For well-baby care visits, except as provided in the final contract;
41. For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided in the final contract or mandated by law;
42. For screening examinations including X-ray examinations made without film, except as provided in the final contract;
43. For immunizations required for foreign travel;
44. For the treatment of sexual dysfunction that is not related to organic disease or injury;
45. For any care related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, and mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change;
46. For any care, treatment, or service which has been disallowed under the provisions of the Health Care Management Services program;
47. For otherwise covered services ordered by a court or other tribunal as part of the member's or dependent's sentence;
48. For therapy services for which there is no expectation of restoring or improving a level of function exists, or for maintenance treatment, when no additional functional progress is expected to occur, unless Medically Necessary and Appropriate;
49. For any illness or injury suffered after the member's effective date during the member's commission of a felony;
50. For elective abortions, except those abortions necessary to avert the death of the Mother, or to terminate pregnancies caused by rape or incest;
51. For maternity services for Dependent daughters except for complications of pregnancy; and
52. For any other medical or dental service or treatment except as provided in the final contract or as mandated by law.

State System of Higher Education
Prescription Drug Card Program*
Effective July 1, 2004

Benefits	Retail Pharmacy	Mail Service Pharmacy
Deductible *Per Calendar Year*	$100 Individual $300 Family	
Generic Prescription Drug	$5 copayment	$10 copayment
Brand Formulary Prescription Drug	$10 copayment	$20 copayment
Brand Non-Formulary Prescription Drug	$20 copayment	$40 copayment
Days Supply *(per prescription)*	Up to 30-days	Up to 90-days
Generic Substitution	When you purchase a brand drug that has a generic equivalent you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs, unless your physician requests that the brand name drug be dispensed.	
Out of Pocket Maximum	Not Applicable	
Network Pharmacy	Pharmacy Files Claim at Point-of-Sale	
Non-Network Pharmacy	Member Files Claim	
Prescription Drug Categories		
Contraceptives *(oral and injectable)*	Covered	
Fertility Agents	Covered	
Fluoride Products	Covered	
Insulin and Diabetic Supplies	Covered	
Smoking Deterrents *(prescription)*	Covered	
Vitamins *(prescription)*	Covered	
Weight Loss Drugs	Covered	
Allergy Serum	Covered Under Medical Program	
Durable Medical Equipment	Covered Under Medical Program	
Prescription Hair Growth Products	Not Covered	
Care Management Programs		
Quantity Level Limits *on select prescription drugs*	Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines.	
Managed Rx Coverage *on certain drug therapies*	Not Applicable	
Managed Prior Authorizations *on select prescription drugs*	Applies only on select prescription drugs***	

Customized

**** This program applies to all active employees and annuitants under the age of 65 retired on or after July 1, 2004***

****** Prescription Drugs that require Prior Authorization: Growth Hormones***

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Prescription Drug Program Exclusions

Except as specifically provided in the contract or benefit booklet, you are not covered for the following services, supplies or charges when provided by a Pharmacy Provider.

1. Any amounts the member is required to pay directly to the Pharmacy Provider for each prescription order or refill order.
2. Charges for a prescription drug when such drug or medication is used for unlabeled or unapproved indications where such use has not been approved by the Food and Drug Administration (FDA);
3. Any drug or medication which is otherwise excluded under the terms of the Agreement;
4. Allergy serums provided by a pharmacy provider;
5. Hair growth stimulants;
6. Food supplements provided by a pharmacy provider;
7. Immunizations and biologicals provided by a pharmacy provider;
8. Any drugs used to abort a pregnancy when provided by a pharmacy provider;
9. Any drugs prescribed for cosmetic purposes only;
10. Any drugs requiring intravenous administration, except insulin and other injectables used to treat diabetes;
11. Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances);
12. Any drugs that can be purchased without a prescription order;
13. Any Prescription Drug which is Experimental/Investigational in nature as determined by Blue Shield in accordance with this Program.