

Summary of Fair Care Fund High Risk Pool PPO Benefits

Effective 10/1/2010
Group 25366-01, 02, 03, 04

With PPO, or Preferred Provider Organization, if members receive services from a provider who is in the PPO network, members will receive the highest level of benefits. If members receive services from a provider who is not in the PPO network, members will be responsible for paying any balance due after Highmark pays the provider based on Highmark PRC (which could be significant) and a higher share of the coinsurance. We urge members to seek all care from network providers to receive the highest reimbursement. In either case, members coordinate their own care.

There is a waiting list for an applicant for which there is no Federal funding available. This is a catastrophic plan featuring high cost sharing and OOP Maximums. High Risk Pools are designed for residents who cannot obtain other coverage due to pre-existing health conditions. This program ends December 31, 2013.

This is a Statewide offering to eligible PA residents who have been uninsured for at least six months and who are not eligible for Medicaid, Medicare, CHIP or private insurance with benefits that are equal to at least 90% of the Fair Care Program's benefits and cost no more than 150% of the program's premium and who have a pre-existing condition or were denied insurance due to a pre-existing condition or were offered coverage only with the exclusion of a pre-existing condition or were offered coverage at 150% of the standard premium due to the pre-existing condition. Limits are combined across in and out of network care.

Benefit	Network	Out of Network
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual	\$1,000	\$10,000
Plan Payment Level – Based on the provider's reasonable charge (PRC)	80%	50%
Member Coinsurance	20%	50%
Out-of-Pocket Maximums (Once met, plan payment level becomes 100%)	\$5,000	\$20,000
Lifetime Maximum	Unlimited	
Precertification Requirements	Performed by Provider All inpatient care must be pre-authorized.	Care provided out of the network -- member needs to notify provider that pre-auth is required for all inpatient care or must obtain authorization within 48 hours or as soon as reasonably possible.
Primary Care Physician Office Visits	100% (unlimited) w/ \$25 copay per visit/per provider	50% after deductible is met
Specialist Office Visits	100% (unlimited) w/ \$30 copay	50% after deductible is met
Preventive Care		
Adult & Pediatric:	100%	50% after deductible is met
Routine physical exams	(Follows Highmark Preventative Schedule)	(Follows Highmark Preventative Schedule)
Immunizations	100%	50% after deductible is met
Routine gynecological exams, including a PAP Test	100%	50% after deductible is met
Mammograms, annual routine and medically necessary	100%	50% after deductible is met
Fecal Occult Blood Test (One test per calendar year beginning at age 50)	100%	50% after deductible is met
Flexible Sigmoidoscopy (One test every three calendar years beginning at age 50)	100%	50% after deductible is met
Routine Colonoscopy (One test every 10 calendar years beginning at age 50)	100%	50% after deductible is met

PSA (One test every calendar year beginning at age 50)	100%	50% after deductible is met
Nutritional Counseling for Weight Management	100%	50% after deductible is met
Abortions	Elective abortions are not covered. 80% after deductible is met for non-elective abortions meeting the criteria for coverage.	Elective abortions are not covered. 50% after deductible is met for non-elective abortions meeting the criteria for coverage.
Allergy Testing	Not Covered	Not Covered
Ambulance/Emergency Transportation	80% after deductible is met	50% after deductible is met
Assisted Fertilization Procedures	Not Covered	Not Covered
Autism Spectrum Disorder (Act 62)	Covered to \$36,000 maximum	Covered to \$36,000 maximum
Dental Services Related to Accidental Injury	80% after deductible is met	50% after deductible is met
Diabetes Treatment, Equipment and Supplies (blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological devices for controlling blood sugar, orthotics, and outpatient self management training)	80% after deductible is met	50% after deductible is met
Diagnostic Services (including routine) <i>Advanced Imaging</i> (MRI, CAT Scan, PETscan, etc.)	80% after deductible is met	50% after deductible is met
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology)	80% after deductible is met	50% after deductible is met
Durable Medical Equipment (DME) covered must be medically necessary). Will not include supplies of an expendable nature or items for comfort only.	80% after deductible is met	50% after deductible is met
Enteral Formula	Covered	Covered
Emergency Room Services	80% after deductible is met	50% after deductible is met
Family Planning (Yes, but to exclude fertility treatments such as fertility drugs, surgery, artificial insemination, In vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intracytoplasmic sperm injection (ICSI), donor eggs and embryos & gestational carriers (i.e. as surrogate mothers)	Covered	Covered
Hearing Devices and Exams	Not Covered	Not Covered
Home Infusion Therapy	Covered	Covered
Home Health Care	80% after deductible is met – limited to 30 visits per calendar year combined, in and out of network	50% after deductible is met – limited to 30 visits per calendar year combined, in and out of network
Hospice	80% after deductible is met	50% after deductible is met
Hospital Services – Inpatient	80% after deductible is met – limited to 120 days per calendar year combined, in and out of network	50% after deductible is met – limited to 90 days per calendar year combined, in and out of network
Hospital Services – Outpatient	80% after deductible is met	50% after deductible is met
Infertility Counseling, Testing and Treatment	Not Covered	Not Covered
Mastectomy and Breast Reconstruction (includes prosthetics following mastectomy)	80% after deductible is met	50% after deductible is met

Maternity (facility & professional services)	80% after deductible is met	50% after deductible is met
Medical/Surgical Expenses	80% after deductible is met	50% after deductible is met
Mental Health – Inpatient	80% after deductible is met – limited to 120 days per calendar year in network	50% after deductible is met – limited to 90 days per calendar year out of network
Mental Health – Outpatient	100% (unlimited) w/ \$30 copay per visit/per provider	50% after deductible is met
Newborn Care – 31 days	80% after deductible is met – for the first 31 days	50% after deductible is met – for the first 31 days
Oral Surgery	Covered only for accidental injury, congenital deformity, or bone impacted wisdom teeth.	Covered only for accidental injury, congenital deformity, or bone impacted wisdom teeth.
Pediatric Extended Care	Not Covered	Not Covered
Private Duty Nursing	Not Covered	Not Covered
Skilled Nursing Facility Care (precertification is required)	80% after deductible is met – limited to 60 days per calendar year in and out network combined	50% after deductible is met – limited to 60 days per calendar year in and out of network combined
Spinal Manipulations	Not Covered	Not Covered
Substance Abuse – Inpatient Detoxification	80% after deductible is met – limited to 120 days per calendar year in network	50% after deductible is met – limited to 90 days per calendar year out of network
Substance Abuse – Inpatient Rehabilitation	80% after deductible is met – limited to 120 days per calendar year in network	50% after deductible is met – limited to 90 days per calendar year out of network
Substance Abuse – Outpatient	100% (unlimited - no referrals required) w/ \$30 copay	50% after deductible is met
Therapy Services Outpatient (Cardiac Rehab, Infusion Therapy, Respiratory/Pulmonary, Chemotherapy, Radiation Therapy and Dialysis) Physical Therapy Speech Therapy Occupational Therapy	\$30 copay per visit - limited to PT and OT combined 15 visit limit, in and out of network combined; ST 15 visit limit, in and out of network combined; Cardiac Rehab 36 visits combined in and out of network; and Respiratory/Pulmonary Rehab 36 visits combined in and out of network. PT OT and ST visit limit combined	50% after deductible is met -- - limited to PT and OT combined 15 visit limit, in and out of network combined; ST 15 visit limit, in and out of network combined; Cardiac Rehab 36 visits combined in and out of network; and Pulmonary Rehab 36 visits combined in and out of network.
Transplant Services	80% after deductible is met	50% after deductible is met
Premier Prescription Drug Program	<i>Defined by Premiere Gold Pharmacy Network</i> Closed Formulary Copayment: \$20 Generic and \$50 Brand Hard Mandatory Generic Mail Order: Yes Copayment: \$50 Generic and \$125 Brand 90 Day Fill at Retail Provision Copayment: \$60 Generic and \$150 Brand	Not Covered

*Highmark Preventative Schedule applies

*Follows State Mandates