

Milton Hershey School Benefit Comparison 2010



Benefit	PPO Basic		PPO Enhanced	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible <i>Per Calendar Year</i>	None	\$2,000 Individual \$4,000 Family	None	\$250 Individual \$500 Family
Payment Level <i>Based on Provider's Reasonable Charge (PRC)</i>	100% PRC	60% PRC after deductible until OOP max is met, then 100% PRC	100% PRC	80% PRC after deductible until OOP max is met, then 100% PRC
Out-of-Pocket Limit <i>Includes Coinsurance-See benefit booklet for exclusions/details</i>	Not Applicable	\$5,000 Individual \$15,000 Family Aggregate	Not Applicable	\$1,500 Individual \$3,000 Family Aggregate
Lifetime Maximum	Unlimited	\$1 million	Unlimited	\$1 million
Ambulance	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
Assisted Fertilization	Not Covered	Not Covered	Not Covered	Not Covered
Dental Services Related to Accidental Injury	Not Covered	Not Covered	Not Covered	Not Covered
Diabetes Treatment	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
Diagnostic Services <i>(Lab, X-ray, and Medical Tests)</i>	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
DME, Orthotics, Prosthetics	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
Elective Abortion <i>Includes Dependent Daughters</i>	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
Emergency Care <i>Professional Services</i>	100% PRC	100% PRC no deductible	100% PRC	100% PRC no deductible
Emergency Room Services <i>Facility Services</i>	100% PRC after \$75 copayment (waived if admitted)		100% after \$35 copayment (waived if admitted)	
Enteral Formulae	100% PRC	60% PRC no deductible	100% PRC	80% PRC no deductible
Hearing Care Services	Not Covered	Not Covered	100% PRC	50% PRC after deductible
			\$1,500 total max for both ears per 36 month period which includes device exam, fitting, repairs, and replacements; 1 audiometric exam/diagnostic testing per year	
Home Health Care <i>Excludes Respite Care</i>	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
	90 visits/calendar year		90 visits/calendar year	
Hospice <i>Includes Respite Care</i>	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
	180 days/lifetime (respite care limited to 240 hours/ lifetime)		180 days/lifetime (respite care limited to 240 hours/ lifetime)	
Hospital Expenses <i>IP and OP</i>	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
	365 days 2 pint blood deductible/calendar year		365 days 2 pint blood deductible/calendar year	

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Infertility Counseling, Testing & Treatment	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
Maternity <i>Includes Dependent Daughters</i>	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
Medical Care <i>Includes Inpatient Visits and Consultations</i>	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
Mental Health – IP* <i>Includes Partial Hospitalization (2 for 1 trade)</i>	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
	Unlimited		Unlimited	
Mental Health – OP	100% PRC after \$20 copayment	60% PRC after deductible	100% PRC after \$5 copayment	80% PRC after deductible
	Unlimited		Unlimited	
Office Visits	100% PRC after \$20 copayment	60% PRC after deductible	100% PRC after \$5 copayment	80% PRC after deductible
Physical Medicine – Outpatient	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
	20 visits/calendar year		30 visits/calendar year	
Oral Surgery	100% PRC	60% PRC after deductible	100% PRC	60% PRC after deductible
Preventive Care <i>Routine Adult Services</i> <i>Include:</i> <i>Physical Exam</i> <i>Gynecological Exam & Pap Test</i> <i>Mammograms</i> <i>Preventive Care 2000</i>	100% PRC after \$20 copayment	60% PRC after deductible	100% PRC after \$5 copayment	80% PRC after deductible
	100% PRC after \$20 copayment	60% PRC no deductible/ maximum	100% PRC after \$5 copayment	80% PRC no deductible/ maximum
	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
Routine Pediatric Services <i>Include:</i> <i>Physical Exams</i> <i>Pediatric Immunizations</i> <i>Preventive Care 2000</i>	100% PRC after \$20 copayment	60% PRC after deductible	100% PRC after \$5 copayment	80% PRC after deductible
	100% PRC	60% PRC no deductible/ maximum	100% PRC	80% PRC no deductible/ maximum
	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
Private Duty Nursing	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
	240 hours/calendar year		240 hours/calendar year	

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Skilled Nursing Facility Care	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
	100 days/calendar year		100 days/calendar year	
Speech & Occupational Medicine <i>Outpatient</i>	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
	12 visits/calendar year per type of therapy		12 visits/calendar year per type of therapy	
Spinal Manipulations	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
	20 visits/calendar year		30 visits/calendar year	
Substance Abuse – Detox	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
	7 days/admission; 4 admissions/lifetime		7 days/admission; 4 admissions/lifetime	
Substance Abuse – IP Rehab <i>Includes Partial Hospitalization (2 for 1 trade)</i>	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
	30 days/calendar year; 90 days lifetime		30 days/calendar year; 90 days lifetime	
Substance Abuse – OP	100% PRC after \$20 copayment	60% PRC after deductible	100% PRC after \$5 copayment	80% PRC after deductible
	30 visits/calendar year; 120 visits/lifetime		30 visits/calendar year; 120 visits/lifetime	
Surgical Expenses <i>Includes Assistant Surgery, Anesthesia, Sterilization, Reversal Procedures and Neonatal Circumcisions</i>	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
Therapy Services <i>Chemotherapy Radiation Therapy Dialysis Infusion Therapy Respiratory Therapy</i>	100% PRC	60% PRC after deductible	100% PRC	80% PRC after deductible
Precertification Requirements for IP Admissions <i>No Penalty for Non-compliance</i>	Performed by Network Provider	Performed by Member	Performed by Network Provider	Performed by Member
Condition Management	Case Management, Blues on Call and Disease State Management		Case Management, Blues on Call and Disease State Management	

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Prescription Drug Program Benefits	PPOBlue Basic		PPOBlue Enhanced	
	Retail	Mail Order	Retail	Mail Order
Deductible	None	None	None	None
Generic Prescription Drug	\$10 copayment	\$20 copayment	\$5 copayment	\$0 copayment
Brand Prescription Drug	Not Applicable	Not Applicable	\$10 copayment	\$20 copayment
Brand Formulary Prescription Drug	\$30 copayment	\$40 copayment	Not Applicable	Not Applicable
Brand Non-Formulary Prescription Drug	\$50 copayment	\$80 copayment	Not Applicable	Not Applicable
Days Supply (<i>per prescription</i>)	Up to 30 day supply (with 1 refill – mandatory mail provision)	Up to 90 day supply	Up to 30 day supply (with 1 refill – mandatory mail provision)	Up to 90 day supply
Generic Substitution (<i>Soft</i>)	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.		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	\$1,000 per person	Not Applicable	\$250 Individual \$500 Family
Claim Submission	Pharmacy Files at Point-of-Sale		Pharmacy Files at Point-of-Sale	
Non-Network Pharmacy	Not Covered		Not Covered	
Contraceptives (<i>oral and injectable</i>)	Covered		Covered	
Quantity Level Limits <i>on select prescription drugs</i>	Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines		Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines	
Managed Rx Coverage <i>on certain drug therapies</i>	Not Applicable		Not Applicable	
Managed Prior Authorizations	Applies on select high cost drugs		Applies on select high cost drugs	

Additional Information: View Highmark Blue Shield's formulary at www.highmarkblueshield.com