GOODYEAR
RETIREE HEALTHCARE TRUST

2015 Summary of Benefits-National PPO

This Summary of Benefits is a brief description of covered services. More details can be found in the Covered Services section.

Benefits	Network	Out-of-Network
General Provisions		
Benefit Period	Calendar Year	
Deductible (per benefit period) Individual Family	 $400 $800	 $1,200 $2,400
Plan Payment Level - Based on the provider's reasonable charge (PRC)	90% after deductible until out-of-pocket limit is met; then 100%	70% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits (Does not include copayment amounts) Individual Family	 $1,800 $3,600	 $5,400 $10,800
Lifetime Maximum (per member)	$2,000,000	
Office Visits[1]		
Primary Care Physician Office Visits[2]	100% after $25 copayment; deductible does not apply	70% after deductible
Specialist Office Visits	100% after $35copayment; deductible does not apply	70% after deductible
Preventive Care Services (includes ANY routine service regardless if on Highmark Preventive Schedule or not)		
Adult		
Routine physical exams	100%; deductible does not apply	Not Covered
Adult Immunizations	100%; deductible does not apply	Not Covered
Routine screening tests and procedures	100%; deductible does not apply	Not Covered
Routine gynecological exams, including a PAP Test	100%; deductible does not apply	Not Covered
Mammograms Annual routine Medically necessary	 100%; deductible does not apply 100%; deductible does not apply	 Not Covered 70% after deductible
Pediatric		
Routine physical exams	100%; deductible does not apply	Not Covered
Pediatric immunizations	100%; deductible does not apply	Not Covered
Routine screening tests and procedures	100%; deductible does not apply	Not Covered
Routine Hearing and Vision Examination	100%; deductible does not apply	Not Covered

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Benefits	Network	Out-of-Network
Emergency Room Services		
Emergency Room	100% after $100 copayment (waived if admitted as an inpatient); deductible does not apply	
Urgent Care Facility	100% after $35 copayment; deductible does not apply	
Professional	100%; deductible does not apply	
Hospital Services		
Hospital Services - Inpatient	90% after deductible	70% after deductible
Hospital Services - Inpatient Rehabilitation Therapy	90% after deductible	70% after deductible
	Combined Limit: 60 days per Benefit Period	
Hospital Services - Outpatient[3]	90% after deductible	70% after deductible
Therapy and Rehabilitation Services		
Spinal Manipulations	100% after $25 copayment; deductible does not apply	70% after deductible
	Combined Limits: 30 visits per benefit period	
Physical Medicine	100% after $25 copayment; deductible does not apply	70% after deductible
	Combined Limit: 60 visits per benefit period. Visit limit includes Occupational Therapy services	
Speech Therapy	100% after $25 copayment; deductible does not apply	70% after deductible
	Combined Limit: 20 visits per benefit period	
Occupational Therapy	100% after $25 copayment; deductible does not apply	70% after deductible
	Combined Limit: 60 visits per benefit period Visit limit includes Physical Medicine services	
Cardiac Rehabilitation, Chemotherapy, and Dialysis Treatment	90% after deductible	70% after deductible
Infusion Therapy	90% after deductible	70% after deductible
Radiation Therapy	90% after deductible	70% after deductible
Respiratory Therapy	90% after network deductible	
Diagnostic Services		
Diagnostic Services (Lab, x-ray, allergy testing and other diagnostic medical tests)	90% after deductible	70% after deductible
Chiropractor x-ray	100%, no deductible	70% after deductible
	$100 maximum per person per benefit period for chiropractic x-rays	

GOODYEAR
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Benefits	Network	Out-of-Network
Behavioral Health Services		
Mental Health Care Services - Inpatient	90% after deductible	70% after deductible
Mental Health Care Services - Outpatient	100% after $35 copayment; deductible does not apply	70% after deductible
Substance Abuse Services - Inpatient Detoxification	90% after deductible	70% after deductible
Substance Abuse Services - Inpatient Residential Treatment and Inpatient/Outpatient Rehabilitation Services	Not Covered	Not Covered
Substance Abuse Services - Outpatient Detoxification	100% after $35 copayment; deductible does not apply	70% after deductible
Other Services		
Allergy Extracts and Injections (in-office services)	90% after deductible	70% after deductible
Assisted Fertilization Treatment	Not Covered	
Ambulance	100%; deductible does not apply	
Dental Services Related to Accidental Injury (medical)	90% after deductible	70% after deductible
Diabetes Treatment	90% after deductible	70% after deductible
Durable Medical Equipment, Prosthetics, Orthotics	90% after network deductible	
	Combined Limits: Wigs are limited to one per benefit period. Mastectomy bras are limited to two per benefit period. Breast Prosthesis is limited to one per benefit period (two if double mastectomy).	
Enteral Formulae	90% after deductible	70% after deductible
Home Infusion Therapy	90% after network deductible	
Home Health Care	90% after deductible	70% after deductible
		Limit: 30 visits per benefit period
Hospice	100%; deductible does not apply	100%; deductible does not apply
Infertility Counseling, Testing and Treatment	Not Covered	
Maternity (facility and professional services)	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
Skilled Nursing Facility Care	90% after deductible	70% after deductible
Medical/Surgical Expenses (except office visits)	90% after deductible	70% after deductible

GOODYEAR
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Benefits	Network	Out-of-Network
Transplant Services Except for Kidney & Cornea transplants, which are subject to program Hospital & Professional benefit limitations including lifetime maximum.	100%; deductible does not apply Transplant Maximum: $1,000,000 per lifetime.	Not Covered
	Transportation, Lodging & Meals Maximum: $10,000 per occurrence[4]	Not Covered
Precertification Requirements	Yes[5]	

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during a benefit period will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

[1] You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

[2] A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.

[3] Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.

[4] The "occurrence" reflects per transplant. A multiple organ transplant would constitute one occurrence. The maximum benefit of $10,000 includes any follow up care needed from the original transplant service".

[5] Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. 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.