HIGHMARK. PPOBlue
A Preferred-Provider Program

Summary of PPOBlue Option I *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. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period.

Municipal Employers Insurance Trust (MEIT)

Benefit	Network	Out-of-Network
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual Family	 None None	 $250 $500
Plan Payment Level – Based on the provider's reasonable charge (PRC)	100%	80% after deductible
Out-of-Pocket Maximums (Once met, plan payment level becomes 100%) Individual Family	 None None	 $2,000 $4,000
Autism Spectrum Disorders Maximum (per person)(2)	$36,000/benefit period	
Lifetime Maximum (per person)	Unlimited	$1,000,000
Primary Care Physician Office Visits	100% after $10 copayment	80% after deductible
Specialist Office Visits	100% after $10 copayment	80% after deductible
Preventive Care		
Adult		
Routine physical exams	100% after $10 copayment	Not Covered
Adult Immunizations	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100% after $10 copayment	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	80% after deductible
Pediatric Routine physical exams	 100% after $10 copayment	 Not Covered
Pediatric immunizations	100%	80% (deductible does not apply)
Emergency Room Services	100% after $20 copayment (waived if admitted)	
Spinal Manipulations	100%	80% after deductible
Physical Medicine	100% after $10 copayment	80% after deductible
Speech Therapy	100% after $10 copayment	80% after deductible
Occupational Therapy	100% after $10 copayment	80% after deductible
Allergy Extracts and Injections	100%	80% after deductible
Ambulance	100%	
Applied Behavior Analysis for Autism Spectrum Disorders(2)	100%	80% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	100%	80% after deductible
Diabetes Treatment	100%	80% after deductible
Diagnostic Services (including routine) ***Advanced Imaging*** (MRI, CAT Scan, PET scan, etc.)	 100%	 80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible
Enteral Formulae	100%	80% (deductible does not apply)
Home Infusion Therapy	100%	100%
Home Health Care	100%	80% after deductible Limit: 50 visits/benefit period
Hospice	100%	80% after deductible

Benefit	Network	Out-of-Network
Hospital Services – Inpatient	100%	80% after deductible
Hospital Services – Outpatient	100%	80% after deductible
Infertility Counseling, Testing and Treatment(3)	100%	80% after deductible
Maternity (facility & professional services)	100%	80% after deductible
Medical/Surgical Expenses (except office visits)	100%	80% after deductible
Mental Health – Inpatient(4)	100%	80% after deductible
Mental Health – Outpatient(4)	100%	80% after deductible
Private Duty Nursing	100%	100% (limit: $500/benefit period)
Respiratory Therapy	100%	
Skilled Nursing Facility Care	100%	80% after deductible Limit: 50 days/benefit period
Substance Abuse – Inpatient Detoxification	100%	80% after deductible
Substance Abuse – Inpatient Rehabilitation	100%	80% after deductible
Substance Abuse – Outpatient	100%	80% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
Transplant Services	100%	80% after deductible
Precertification Requirements(5)	Yes	
Prescription Drug Deductible Individual Family	Per benefit period None None	
Premier Prescription Drug Program Mandatory Generic(6) *Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.*	**Retail Drugs (31-day Supply)** $5 generic copayment $15 formulary brand copayment $30 non-formulary brand copayment Mandatory Generic⑤ **Maintenance Drugs through Mail Order (90-day Supply)** $10 generic copayment $30 formulary brand copayment $60 non-formulary brand copayment Mandatory Generic (6)	

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31
(2) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits
(3) 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.
(4) State mandated minimum benefits may apply to a diagnosis of serious mental illness (If the above grid does not show a limit, your mental health benefit days and visits are unlimited).
(5) Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related 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, you will be responsible for payment of any costs not covered.
(6) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. You are responsible for the payment differential when a generic drug is authorized by your doctor and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.