

## Summary of PPOBlue Option II 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
<b>Benefit Period</b> <sup>(1)</sup>	Calendar Year	
<b>Deductible</b> (per benefit period)		
Individual	None	\$250
Family	None	\$500
<b>Plan Payment Level</b> – Based on the provider's reasonable charge (PRC)	100%	80% after deductible
<b>Out-of-Pocket Maximums</b> (Once met, plan payment level becomes 100%)		
Individual	None	\$1,500
Family	None	\$3,000
<b>Autism Spectrum Disorders Maximum</b> (per person) <sup>(2)</sup>	\$36,000/benefit period	
<b>Lifetime Maximum</b> (per person)	Unlimited	\$1,000,000
<b>Primary Care Physician Office Visits</b>	100% after \$10 copayment	80% after deductible Limit: 15 visits/benefit period
<b>Specialist Office Visits</b>	100% after \$10 copayment	80% after deductible Limit: 15 visits/benefit period
<b>Preventive Care</b>		
<i>Adult</i>		
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
<i>Pediatric</i>		
Routine physical exams	100% after \$10 copayment	Not Covered
Pediatric immunizations	100%	80% (deductible does not apply)
<b>Emergency Room Services</b>	100% after \$25 copayment (waived if admitted)	
<b>Spinal Manipulations</b>	100%	80% after deductible
	Limit: 25 visits/benefit period	
<b>Physical Medicine</b>	100%	80% after deductible
<b>Speech Therapy</b>	100%	100% after deductible
<b>Occupational Therapy</b>	100%	80% after deductible
<b>Allergy Extracts and Injections</b>	100%	80% after deductible
<b>Ambulance</b>	100%	
<b>Applied Behavior Analysis for Autism Spectrum Disorders</b> <sup>(2)</sup>	100%	80% after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Dental Services Related to Accidental Injury</b>	100%	80% after deductible
<b>Diabetes Treatment</b>	100%	80% after deductible
<b>Diagnostic Services</b> (including routine)		
<i>Advanced Imaging</i> (MRI, CAT Scan, PET scan, etc.)	100%	80% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100%	100% after deductible
<b>Enteral Formulae</b>	100%	80% (deductible does not apply)
<b>Home Infusion Therapy</b>	100%	100% after deductible

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Home Health Care</b>	100%	100%
	Combined limit: 100 visits/benefit period	
<b>Hospice</b>	100%	100% after deductible
<b>Hospital Services – Inpatient</b>	100%	80% after deductible
<b>Hospital Services – Outpatient</b>	100%	80% after deductible
<b>Infertility Counseling, Testing and Treatment<sup>(3)</sup></b>	100%	80% after deductible
<b>Maternity</b> (facility & professional services)	100%	80% after deductible
<b>Medical/Surgical Expenses</b> (except office visits)	100%	80% after deductible
<b>Mental Health – Inpatient<sup>(4)</sup></b>	100%	80% after deductible
<b>Mental Health – Outpatient<sup>(4)</sup></b>	100% after \$10 payment	80% after deductible
<b>Private Duty Nursing</b>	100%	
	Limit: \$20,000/calendar year	
<b>Respiratory Therapy</b>	100%	100% after deductible
<b>Skilled Nursing Facility Care</b>	100%	80% after deductible Limit: 100 days/benefit period
<b>Substance Abuse – Inpatient Detoxification</b>	100%	80% after deductible
<b>Substance Abuse – Inpatient Rehabilitation</b>	100%	80% after deductible
<b>Substance Abuse – Outpatient</b>	100% after \$10 copayment	80% after deductible
<b>Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
<b>Transplant Services</b>	100%	80% after deductible
<b>Precertification Requirements<sup>(5)</sup></b>	Yes	
<b>Prescription Drug Deductible</b> Individual Family	Per benefit period None None	
<b>Premier Prescription Drug Program</b> Mandatory Generic <sup>(6)</sup> <i>Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>	<p><b>Retail Drugs (31-day Supply)</b> \$5 generic copayment \$15 formulary brand copayment \$30 non-formulary brand copayment Mandatory Generic<sup>(6)</sup></p> <p><b>Maintenance Drugs through Mail Order (90-day Supply)</b> \$10 generic copayment \$30 formulary brand copayment \$60 non-formulary brand copayment Mandatory Generic (6)</p>	

(1) Your group's benefit period is based on a Calendar 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.