

## Summary of Premium PPOBlue \$10 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.

Benefit	Network	Out-of-Network
<b>Benefit Period</b> <sup>(1)</sup>	Contract 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	\$2,000
Family	None	\$4,000
<b>Lifetime Maximum</b> (per person)	Unlimited	Unlimited
<b>Primary Care Physician Office Visits</b>	100% after \$10 copayment	80% after deductible
<b>Specialist Office Visits</b>	100% after \$10 copayment	80% after deductible
<b>Preventive Care</b> <sup>(2)</sup>		
<b>Routine Adult</b>		
Physical exams	100%	Not Covered
Adult immunizations	100%	80% after deductible
Colorectal cancer screening	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100%	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
<b>Routine Pediatric</b>		
Physical exams	100%	Not Covered
Pediatric immunizations	100%	80% (deductible does not apply)
Diagnostic services and procedures	100%	80% after deductible
<b>Emergency Room Services</b>	100% after \$35 copayment (waived if admitted)	
<b>Spinal Manipulations</b>	100% after \$10 copayment	80% after deductible
	Limit: 20 visits/benefit period	
<b>Physical Medicine</b>	100% after \$10 copayment	80% after deductible
	Limit: 20 visits/benefit period	
<b>Speech Therapy</b>	100% after \$10 copayment	80% after deductible
	Limit: 20 visits/benefit period	
<b>Occupational Therapy</b>	100% after \$10 copayment	80% after deductible
	Limit: 20 visits/benefit period	
<b>Allergy Extracts and Injections</b>	100%	80% after deductible
<b>Ambulance</b>	100%	
<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>		
<i>Advanced Imaging</i> (MRI, CAT, 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%	80% after deductible
<b>Enteral Formulae</b>	100%	80% (deductible does not apply)
<b>Home Infusion Therapy</b>	100%	
<b>Home Health Care</b>	100%	
<b>Hospice</b>	100%	
<b>Hospital Services</b>		
Inpatient	100%	80% after deductible
Outpatient	100%	80% after deductible
<b>Infertility Counseling, Testing and Treatment</b> <sup>(3)</sup>	100%	80% after deductible
<b>Maternity</b> (non-preventive facility & professional services)	100%	80% after deductible
<b>Medical/Surgical Expenses</b> (except office visits)	100%	80% after deductible
<b>Mental Health</b>		
Inpatient	100%	80% after deductible
Outpatient	100%	80% after deductible
<b>Private Duty Nursing</b>	100%	
<b>Respiratory Therapy</b>	100%	
<b>Skilled Nursing Facility Care</b>	100%	80% after deductible
		Limit: 100 days/benefit period
<b>Substance Abuse</b>		
Inpatient Detoxification	100%	80% after deductible
Inpatient Rehabilitation	100%	80% after deductible
Outpatient	100%	80% after deductible

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<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</b> (4)		Yes
<b>Prescription Drug Deductible</b> Individual Family		None None
<b>Premier Prescription Drug Program</b> Mandatory Generic(5) <i>Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>		<b>Retail Drugs (31/60/90-day Supply)</b> \$8/\$16/\$24 generic copayment \$30/\$60/\$90 formulary brand copayment \$55/\$110/\$165 non-formulary copayment  <b>Maintenance Drugs through Mail Order (90-day Supply)</b> \$16 generic copayment \$60 formulary brand copayment \$110 non-formulary brand copayment

- (1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's renewal date. Contact your employer to determine the renewal date applicable to your program.
- (2) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
- (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) 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.
- (5) 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.