HIGHMARK. PPOBlue A Preferred-Provider Program

# *Summary of* Premium PPOBlue $20 *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 |
|---|---|---|
| **Benefit Period**(1) | Contract Year | |
| **Deductible** (per benefit period) | | |
| Individual | None | $500 |
| Family | None | $1,000 |
| **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 | None | $3,000 |
| Family | None | $6,000 |
| **Lifetime Maximum** (per person) | Unlimited | Unlimited |
| **Primary Care Physician Office Visits** | 100% after $20 copayment | 80% after deductible |
| **Specialist Office Visits** | 100% after $20 copayment | 80% after deductible |
| **Preventive Care**(2) | | |
| ***Routine Adult*** | | |
| 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 |
| ***Routine Pediatric*** | | |
| Physical exams | 100% | Not Covered |
| Pediatric immunizations | 100% | 80% (deductible does not apply) |
| Diagnostic services and procedures | 100% | 80% after deductible |
| **Emergency Room Services** | 100% after $50 copayment (waived if admitted) | |
| **Spinal Manipulations** | 100% after $20 copayment | 80% after deductible |
| | Limit: 20 visits/benefit period | |
| **Physical Medicine** | 100% after $20 copayment | 80% after deductible |
| | Limit: 20 visits/benefit period | |
| **Speech Therapy** | 100% after $20 copayment | 80% after deductible |
| | Limit: 20 visits/benefit period | |
| **Occupational Therapy** | 100% after $20 copayment | 80% after deductible |
| | Limit: 20 visits/benefit period | |
| **Allergy Extracts and Injections** | 100% | 80% after deductible |
| **Ambulance** | 100% | |
| **Assisted Fertilization Procedures** | Not Covered | |
| **Dental Services Related to Accidental Injury** | 100% | 80% after deductible |
| **Diabetes Treatment** | 100% | 80% after deductible |
| **Diagnostic Services** | | |
| *Advanced Imaging* (MRI, CAT, 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% | |
| **Home Health Care** | 100% | 80% after deductible |
| **Hospice** | 100% | 80% after deductible |
| **Hospital Services** | | |
| Inpatient | 100% | 80% after deductible |
| Outpatient | 100% | 80% after deductible |
| **Infertility Counseling, Testing and Treatment**(3) | 100% | 80% after deductible |
| **Maternity** (non-preventive facility & professional services) | 100% | 80% after deductible |
| **Medical/Surgical Expenses** (except office visits) | 100% | 80% after deductible |
| **Mental Health** | | |
| Inpatient | 100% | 80% after deductible |
| Outpatient | 100% | 80% after deductible |
| **Private Duty Nursing** | 100% | |
| **Respiratory Therapy** | 100% | |
| **Skilled Nursing Facility Care** | 100% | 80% after deductible<br>Limit: 100 days/benefit period |
| **Substance Abuse** | | |
| Inpatient Detoxification | 100% | 80% after deductible |
| Inpatient Rehabilitation | 100% | 80% after deductible |
| Outpatient | 100% | 80% after deductible |

| Benefit | Network | Out-of-Network |
|---|---|---|
| **Therapy Services** (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) | 100% | 80% after deductible |
| **Transplant Services** | 100% | 80% after deductible |
| **Precertification Requirements**(4) | Yes | |
| **Prescription Drug Deductible**<br>Individual<br>Family | <br>None<br>None | |
| **Premier Prescription Drug Program**<br>Mandatory Generic(5)<br>*Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* | **Retail Drugs (31/60/90-day Supply)**<br>$8/$16/$24 generic copayment<br>$40/$80/$120 brand copayment<br><br>**Maintenance Drugs through Mail Order (90-day Supply)**<br>$16 generic copayment<br>$80 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) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. To obtain a prescription medication that is not included on this formulary, the physician must complete the 'Prescription Drug Medication Request Form' and return it to the Pharmacy Affairs Department for clinical review.Under the mandatory generic provision, you are responsible for the payment differential when a generic drug is available and you or your doctor specifies a brand name drug. Your payment is the price difference between the brand drug and the generic drug in addition to the brand drug copayment or coinsurance amounts, which may apply.