Summary of PPO *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	In-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)	80% until out-of-pocket maximum is met, then 100%	60% after deductible until out-of-pocket maximum is met; then 100%
Out-of-Pocket Maximums④ Individual Family	 $1,000 $2,000	 $2,000 $4,000
Lifetime Maximum (per person)	Unlimited	Unlimited
Physician Office Visits	100% after $10 copayment	60% after deductible
Specialist Office Visits	100% after $10 copayment	60% after deductible
Preventive Care⑥ ***Adult*** Routine Physical exams	 100% (deductible/copayment does not apply)	 Not Covered
Adult Immunizations	100% (deductible does not apply)	60% after deductible
Routine gynecological exams, including a PAP Test	100% (deductible/copayment does not apply)	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	60% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	60% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Pediatric Routine physical exams	 100% (deductible/copayment does not apply)	 Not Covered
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Emergency Room Services	100% after $20 copayment (waived if admitted)	
Spinal Manipulations	80%	60% after deductible Limit: 25 visits/calendar year
Physical Medicine	80%	60% after deductible
Speech Therapy	80%	60% after deductible
Occupational Therapy	80%	60% after deductible
Allergy Extracts and Injections	80%	60% after deductible
Ambulance	80%	
Applied Behavior Analysis for Autism Spectrum Disorders (ASD)⑤	80%	60% after deductible
	Limit: $36,000 maximum/calendar year (includes prescription drug expenses)	
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	80%	60% after deductible
Diabetes Treatment	80%	60% after deductible
Diagnostic Services ***Advanced Imaging*** (MRI, CAT Scan, PET scan, etc.)	80%	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80%	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80%	
Enteral Formulae	80% (deductible does not apply)	60% (deductible does not apply)
Home Infusion Therapy	80%	
Home Health Care	80%	

Benefit	In-Network	Out-of-Network
Hospice	80%	
Hospital Services – Inpatient	80%	60% after deductible
Hospital Services – Outpatient	80%	60% after deductible
Infertility Counseling, Testing and Treatment②	80%	60% after deductible
Maternity (facility & professional services)	80%	60% after deductible
Medical/Surgical Expenses (Except Office Visits)	80%	60% after deductible
Mental Health – Inpatient	80%	60% after deductible
Mental Health – Outpatient	80%	60% after deductible
Pediatric Extended Care Services	80%	60% after deductible
	Limit: 100 days/calendar year	
Private Duty Nursing	80%	
Respiratory Therapy	80%	
Skilled Nursing Facility Care	80%	
Substance Abuse – Inpatient Detoxification	80%	60% after deductible
Substance Abuse – Inpatient Rehabilitation	80%	60% after deductible
Substance Abuse – Outpatient	80%	60% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80%	60% after deductible
Transplant Services	80%	60% after deductible
Precertification Requirements	Performed by Member③	

Questions? Call 1-800-215-7865 Reference Code: XXXXXXXX

For Providers in your area call 1-800-810-BLUE

① Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

② Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy is covered.

③ Highmark Healthcare Management (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.

④ Out-of-pocket maximums do not include copayments, deductibles, prescription drug expenses, or amounts in excess of the Allowable Charge.

⑤ Coverage for eligible members to age 21. Services will be paid according to the benefit category, i.e., speech therapy. Treatment for autism spectrum disorders does not reduce visit/day limits.

⑥ Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.

Benefit	In-Network		Out-of-Network
Premier Prescription Drug Program (Defined by Premier Gold Pharmacy Network - Not Physician Network)	Retail – 34-day supply Mail Order – 90 day supply Mandatory Generic①		Not Covered
Option A	Retail ➢ $5 copayment generic ➢ $10 copayment brand	Mail-Order ➢ $10 copayment generic ➢ $20 copayment brand	
Option B	Retail ➢ $5 copayment generic ➢ $15 copayment brand	Mail Order ➢ $10 copayment generic ➢ $30 copayment brand	
Option C	Retail ➢ $10 copayment generic ➢ $20 copayment brand	Mail Order ➢ $20 copayment generic ➢ $40 copayment brand	
Option D	Retail ➢ $10 copayment generic ➢ $20 copayment brand formulary② ➢ $35 copayment non-formulary	Mail Order ➢ $20 copayment generic ➢ $40 copayment brand formulary② ➢ $70 copayment non-formulary	
Option E	Retail ➢ $15 copayment generic ➢ $30 copayment brand formulary② ➢ $45 copayment non-formulary	Mail Order ➢ $30 copayment generic ➢ $60 copayment brand formulary② ➢ $90 copayment non-formulary	

① The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand drug. The member payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or coinsurance amounts, which may apply.

② The formulary is an extensive list of Food & 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.