HIGHMARK EPOBLUE An Exclusive-Provider Program

Summary of Essential EPOBlue *Benefits*

An EPO, or Exclusive Provider Organization, offers one level of benefits. Except for emergencies, all covered services must be received from an EPO network provider. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. *Essential EPOBlue covers eligible annual expenses up to $75,000 per individual/per benefit period, and covers generic prescription drugs only.* Below are specific benefit levels that apply during your benefit period.

Benefit	Coverage
Benefit Period(1)	Contract Year
Deductible (per benefit period)	
Individual	$250
Family	$500
Plan Payment Level – Based on the provider's reasonable charge (PRC)	80% after deductible
Out-of-Pocket Maximums	
Individual	None
Family	None
Lifetime Maximum (per person)	Unlimited ($75,000 annual maximum)
Primary Care Physician Office Visits	80% after deductible
Specialist Office Visits	80% after deductible
Preventive Care	
Adult	
Routine physical exams	80% (deductible does not apply)
Adult Immunizations	80% after deductible
Colorectal Cancer Screening	
Basic Diagnostic Services	80% after deductible
Medical Surgical	80% after deductible
Routine gynecological exams, including a Pap Test	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	80% (deductible does not apply)
Pediatric	
Routine physical exams	80% (deductible does not apply)
Pediatric immunizations	80% (deductible does not apply)
Emergency Room Services	80% after deductible
Spinal Manipulations	80% after deductible
	Limit: 20 visits/benefit period
Physical Medicine	80% after deductible
	Limit: 20 visits/benefit period
Speech Therapy	80% after deductible
	Limit: 20 visits/benefit period
Occupational Therapy	80% after deductible
	Limit: 20 visits/benefit period
Allergy Extracts and Injections	80% after deductible
Ambulance	80% after deductible
Assisted Fertilization Procedures	Not Covered
Dental Services Related to Accidental Injury	80% after deductible
Diabetes Treatment	80% after deductible
Diagnostic Services (including routine)	
Advanced Imaging (MRI, CAT Scan, PET scan, etc.)	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible
Enteral Formulae	80% (deductible does not apply)
Home Infusion Therapy	80% after deductible
Home Health Care	80% after deductible
Hospice	80% after deductible
Hospital Services – Inpatient(2)	80% after deductible Plus $250 inpatient deductible per admission
Hospital Services – Outpatient	80% after deductible
Infertility Counseling, Testing and Treatment(3)	80% after deductible
Maternity (facility & professional services)	80% after deductible(2)
Medical/Surgical Expenses (except office visits)	80% after deductible

Benefit	Coverage
Mental Health – Inpatient(4)	80% after deductible(2)
Mental Health – Outpatient(4)	80% after deductible
Private Duty Nursing	80% after deductible
Respiratory Therapy	80% after deductible
Skilled Nursing Facility Care	80% after deductible(2) Limit: 100 days/benefit period
Substance Abuse	
Inpatient Detoxification	80% after deductible(2)
Inpatient Rehabilitation	80% after deductible(2)
Outpatient	80% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible
Transplant Services	80% after deductible
Precertification Requirements(5)	Yes
Prescription Drug Deductible	
Individual	None
Family	None
Premier Prescription Drug Program(6) *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)** $10/$20/$30 generic copayment **Maintenance Drugs through Mail Order (90-day Supply)** $20 generic copayment **Brand name drugs are not covered (Discount is available)**(6)

(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) A $250 deductible per admission applies to all inpatient admissions. This is in addition to the overall $250 program deductible.
(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) Your prescription drug program covers only **generic drugs**. Brand name drugs are not covered. However, you can receive a discount off the brand name drug retail price by showing your Highmark identification card at a Premier network pharmacy, or by using the mail order option.