HIGHMARK PPOBlue A Preferred-Provider Program

Summary of Take Charge PPOBue $250 90/70 *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	$250	$500
Family	$500	$1,000
Plan Payment Level – Based on the provider's reasonable charge (PRC)	90% after deductible	70% after deductible
Out-of-Pocket Maximums (Once met, plan payment level becomes 100%)		
Individual	$1,500	$3,000
Family	$3,000	$6,000
Lifetime Maximum (per person)	Unlimited	
Primary Care Physician Office Visits	100% after $20 copayment	70% after deductible
Specialist Office Visits	100% after $30 copayment	70% after deductible
Preventive Care		
A*dult*		
Routine physical exams	100% after $20 copayment	Not Covered
Adult Immunizations	90% after deductible	70% after deductible
Colorectal Cancer Screening		
Diagnostic Services	90% after deductible	70% after deductible
Medical Surgical	90% after deductible	70% after deductible
Routine gynecological exams, including a Pap Test	100% after $30 copayment	70% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	70% after deductible
Pediatric		
Routine physical exams	100% after $20 copayment	Not Covered
Pediatric immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Emergency Room Services	100% after $75 copayment (waived if admitted)	
Spinal Manipulations	100% after $30 copayment	70% after deductible
	Limit: 20 visits/benefit period	
Physical Medicine	100% after $30 copayment	70% after deductible
	Limit: 20 visits/benefit period	
Speech Therapy	100% after $30 copayment	70% after deductible
	Limit: 20 visits/benefit period	
Occupational Therapy	100% after $30 copayment	70% after deductible
	Limit: 20 visits/benefit period	
Allergy Extracts and Injections	90% after deductible	70% after deductible
Ambulance	90% after network deductible	
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible
Diabetes Treatment	90% after deductible	70% after deductible
Diagnostic Services (including routine)		
Advanced Imaging (MRI, CAT Scan, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	70% after deductible
Enteral Formulae	90% (deductible does not apply)	70% (deductible does not apply)
Home Infusion Therapy	90% after network deductible	
Home Health Care	90% after deductible	70% after deductible
Hospice	90% after deductible	70% after deductible
Hospital Services – Inpatient	90% after deductible	70% after deductible
Hospital Services – Outpatient	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment(2)	90% after deductible	70% after deductible

Benefit	Network	Out-of-Network
Maternity (facility & professional services)	90% after deductible	70% after deductible
Medical/Surgical Expenses (except office visits)	90% after deductible	70% after deductible
Mental Health – Inpatient(3)	90% after deductible	70% after deductible
Mental Health – Outpatient(3)	90% after deductible	70% after deductible
Private Duty Nursing	90% after network deductible	
Respiratory Therapy	90% after network deductible	
Skilled Nursing Facility Care	90% after deductible	70% after deductible Limit: 100 days/benefit period
Substance Abuse		
Inpatient Detoxification	90% after deductible	70% after deductible
Inpatient Rehabilitation	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements(4)	Yes	
Prescription Drug Deductible Individual Family	$50 per Contract year $100 per Contract year	
Premier Prescription Drug Program Mandatory Generic(5) *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)** $8/$16/$24 generic copayment $40/$80/$120 brand copayment **Maintenance Drugs through Mail Order (90-day Supply)** $16 generic copayment $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) 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.

(3) 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.)

(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, your doctor 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 name drug and the generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.