

Summary of PPO Blue Family Savings \$3,000C 90/70 Rx A Benefits

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period ⁽¹⁾	Contract Year	
Deductible (per benefit period)		
Individual	\$3,000 Combined family & individual	\$6,000 Combined family & individual
Family		
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period)		
Individual	\$1,000 Combined family & individual	\$2,000 Combined family & individual
Family		
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	90% (deductible does not apply)	70% after deductible
Primary Care Provider Office Visits	90% (deductible does not apply)	70% after deductible
Specialist Office Visits	90% (deductible does not apply)	70% after deductible
Urgent Care Center Visits	90% (deductible does not apply)	70% after deductible
Preventive Care ⁽²⁾		
Routine Adult		
Physical exams	100%	70% after deductible
Adult immunizations	100%	70% after deductible
Colorectal cancer screening	100%	70% after deductible
Routine gynecological exams, including a Pap Test	100%	70% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	70% after deductible
Diagnostic services and procedures	100%	70% after deductible
Routine Pediatric		
Physical exams	100%	70% after deductible
Pediatric immunizations	100%	70% (deductible does not apply)
Diagnostic services and procedures	100%	70% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient		
Hospital Outpatient		
Maternity (non-preventive facility & professional services)	90% after deductible	70% after deductible
Medical/Surgical (except office visits)		
Emergency Services		
Emergency Room Services	90% (deductible does not apply)	
Ambulance	90% after deductible	70% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
Respiratory Therapy	90% after deductible	70% after deductible
Speech & Occupational Therapy	90% after deductible	70% after deductible
	Limit: 20 visits per therapy/benefit period	
Spinal Manipulations	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Mental Health/Substance Abuse		
Inpatient		
Inpatient Detoxification/Rehabilitation	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	Not Covered	Not Covered

Benefit	Network	Out-of-Network
Diagnostic Services <i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
<i>Basic Diagnostic Services</i> (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
Home Health Care	90% after deductible	70% after deductible
	Limit: 90 days/benefit period	
Hospice	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment (3)	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	Limit: 100 days/benefit period	
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements (4)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual Family	None None	
Premier Prescription Drug Program (5) Mandatory Generic <i>Defined by the Premier 2012 Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i> <i>Your plan uses the Comprehensive Formulary.</i>	Retail Drugs (31/60/90-day Supply) \$8/\$16/\$24 generic copayment \$35/\$70/\$105 formulary brand copayment \$50/\$100/\$150 non-formulary copayment Maintenance Drugs through Mail Order (90-day Supply) \$20 generic copayment \$90 formulary brand copayment \$125 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 effective date. Contact your employer to determine the effective 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 Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. 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 provider 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.

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.