

## Summary of Premium PPO Blue \$20 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
<b>General Provisions</b>		
<b>Benefit Period</b> <sup>(1)</sup>	Contract Year	
<b>Deductible</b> (per benefit period)		
Individual	None	\$500
Family	None	\$1,000
<b>Plan Pays</b> – payment based on the plan allowance	100%	80% after deductible
<b>Out-of-Pocket Maximums</b> (Once met, plan pays 100% for the rest of the benefit period)		
Individual	None	\$3,000
Family	None	\$6,000
<b>Office/Clinic/Urgent Care Visits</b>		
<b>Retail Clinic Visits</b>	100% after \$20 copayment	80% after deductible
<b>Primary Care Provider Office Visits</b>	100% after \$20 copayment	80% after deductible
<b>Specialist Office Visits</b>	100% after \$20 copayment	80% after deductible
<b>Urgent Care Center Visits</b>	100% after \$35 copayment	80% after deductible
<b>Preventive Care</b> <sup>(2)</sup>		
<b>Routine Adult</b>		
Physical exams	100%	80% after deductible
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
<b>Routine Pediatric</b>		
Physical exams	100%	80% after deductible
Pediatric immunizations	100%	80% (deductible does not apply)
Diagnostic services and procedures	100%	80% after deductible
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>		
<b>Hospital Inpatient</b>		
<b>Hospital Outpatient</b>	100%	80% after deductible
<b>Maternity</b> (non-preventive facility & professional services)		
<b>Medical/Surgical</b> (except office visits)		
<b>Emergency Services</b>		
<b>Emergency Room Services</b>	100% after \$50 copayment (waived if admitted)	
<b>Ambulance</b>	100%	80% after deductible
<b>Therapy and Rehabilitation Services</b>		
<b>Physical Medicine</b>	100% after \$20 copayment	80% after deductible
	Limit: 20 visits/benefit period	
<b>Respiratory Therapy</b>	100%	80% after deductible
<b>Speech &amp; Occupational Therapy</b>	100% after \$20 copayment	80% after deductible
	Limit: 20 visits per therapy/benefit period	
<b>Spinal Manipulations</b>	100% after \$20 copayment	80% after deductible
	Limit: 20 visits/benefit period	
<b>Other Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
<b>Mental Health/Substance Abuse</b>		
<b>Inpatient</b>		
<b>Inpatient Detoxification/Rehabilitation</b>	100%	80% after deductible
<b>Outpatient</b>	100%	80% after deductible
<b>Other Services</b>		
<b>Allergy Extracts and Injections</b>	100%	80% after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Dental Services Related to Accidental Injury</b>	Not Covered	Not Covered

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Diagnostic Services</b>		
<i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	100%	80% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100%	80% after deductible
<b>Home Health Care</b>	100%	80% after deductible
	Limit: 90 days/benefit period	
<b>Hospice</b>	100%	80% after deductible
<b>Infertility Counseling, Testing and Treatment</b> (3)	100%	80% after deductible
<b>Private Duty Nursing</b>	100%	80% after deductible
	Limit: 240 hours/benefit period	
<b>Skilled Nursing Facility Care</b>	100%	80% after deductible
	Limit: 100 days/benefit period	
<b>Transplant Services</b>	100%	80% after deductible
<b>Precertification Requirements</b> (4)	Yes	
<b>Prescription Drugs</b>		
<b>Prescription Drug Deductible</b>		
Individual		None
Family		None
<b>Premier Prescription Drug Program</b> (5)	<b>Retail Drugs (31/60/90-day Supply)</b>	
Mandatory Generic	\$8/\$16/\$24 generic copayment	
<i>Defined by the Premier 2012 Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>	\$35/\$70/\$105 formulary brand copayment	
	\$50/\$100/\$150 non-formulary copayment	
	<b>Maintenance Drugs through Mail Order (90-day Supply)</b>	
<i>Your plan uses the Comprehensive Formulary.</i>	\$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.