

# Summary of PPOBlue HDHP 90/70 \$3,500 Deductible Benefits

## Qualified High Deductible Health Plan (HDHP)

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). This program should not be combined with any funding arrangement other than an HSA.

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. **If you enroll as an individual, the deductible and out-of-pocket maximums for the "Employee Only Plan" apply. If you enroll as a family, the deductible and out-of-pocket maximums for the "Family Plan" apply and can be satisfied by one or more of your family members.**

Benefit	Network	Out-of-Network
<b>Benefit Period</b> (1)	Contract Year	
<b>Deductible per benefit period</b> (Applies to Medical and Prescription Drug benefits) Employee Only Plan Family Plan	\$3,500 Combined \$7,000 Combined	
<b>Plan Payment Level</b> – Based on the provider's reasonable charge (PRC)	90% after deductible	70% after deductible
<b>Out-of-Pocket Maximums</b> (Includes prescription drug expenses and copayments. Once met, plan payment level becomes 100%) Employee Only Plan Family Plan	\$1,000 \$2,000	\$2,000 \$4,000
<b>Lifetime Maximum</b> (per person)	\$5,000,000 Combined	
<b>Primary Care Physician Office Visits</b>	90% after deductible	70% after deductible
<b>Specialist Office Visits</b>	90% after deductible	70% after deductible
<b>Preventive Care</b>		
<i>Adult</i>		
Routine physical exams	90% (deductible does not apply)	Not Covered
Adult Immunizations	90% after deductible	70% after deductible
Routine gynecological exams, including a Pap Test	90% (deductible does not apply)	70% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 90% (deductible does not apply) Medically necessary: 90% after deductible	70% after deductible
<i>Pediatric</i>		
Routine physical exams	90% (deductible does not apply)	Not Covered
Pediatric immunizations	90% (deductible does not apply)	70% (deductible does not apply)
<b>Emergency Room Services</b>	90% after deductible	
<b>Spinal Manipulations</b>	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
<b>Physical Medicine</b>	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
<b>Speech Therapy</b>	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
<b>Occupational Therapy</b>	90% after deductible	70% after deductible
	Limit: 20 visits/benefit period	
<b>Allergy Extracts and Injections</b>	90% after deductible	70% after deductible
<b>Ambulance</b>	90% after deductible	
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Dental Services Related to Accidental Injury</b>	90% after deductible	70% after deductible
<b>Diabetes Treatment</b>	90% after deductible	70% after deductible
<b>Diagnostic Services (including routine)</b>	90% after deductible	70% after deductible
<i>Advanced Imaging</i> (MRI, CAT Scan, PET scan, etc.)		
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	90% after deductible	70% after deductible
<b>Enteral Formulae</b>	90% after deductible	70% after deductible
<b>Home Infusion Therapy</b>	90% after deductible	

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Home Health Care</b>	90% after deductible	70% after deductible
<b>Hospice</b>	90% after deductible	70% after deductible
<b>Hospital Services – Inpatient</b>	90% after deductible	70% after deductible
<b>Hospital Services – Outpatient</b>	90% after deductible	70% after deductible
<b>Infertility Counseling, Testing and Treatment<sup>(2)</sup></b>	90% after deductible	70% after deductible
<b>Maternity</b> (facility & professional services)	90% after deductible	70% after deductible
<b>Medical/Surgical Expenses</b> (Except Office Visits)	90% after deductible	70% after deductible
<b>Mental Health – Inpatient<sup>(3)</sup></b>	90% after deductible Limit: 30 days/benefit period	70% after deductible Limit: 10 days/benefit period
<b>Mental Health – Outpatient<sup>(3)</sup></b>	90% after deductible Limit: 20 visits/benefit period	70% after deductible Limit: 10 visits/benefit period
<b>Private Duty Nursing</b>	90% after deductible	
<b>Respiratory Therapy</b>	90% after deductible	
<b>Skilled Nursing Facility Care</b>	90% after deductible	70% after deductible Limit: 100 days/benefit period
<b>Substance Abuse – Inpatient Detoxification</b>	90% after deductible	70% after deductible
<b>Substance Abuse – Inpatient Rehabilitation</b>	90% after deductible	70% after deductible
<b>Substance Abuse – Outpatient</b>	90% after deductible	70% after deductible
<b>Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
<b>Transplant Services</b>	90% after deductible	70% after deductible
<b>Precertification Requirements<sup>(4)</sup></b>	Yes	
<b>Prescription Drug Deductible</b> Employee Only Plan Family Plan	Integrated with medical deductible Integrated with medical deductible	
<b>Premier Prescription Drug Program</b> Mandatory Generic <sup>(5)</sup> <i>Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>	<b>Retail Drugs<sup>(5)</sup> (31-day Supply)</b> Plan pays 90% after deductible  <b>Maintenance Drugs through Mail Order<sup>(5)</sup> (90-day Supply)</b> Plan pays 90% after deductible	

- (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 benefits (30 inpatient days and 60 outpatient visits annually with the right to exchange inpatient days for outpatient visits on a one-for-two basis) may apply to a diagnosis of serious mental illness. Serious mental illnesses include: schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa, delusional disorder. Once mental health limits are exhausted, both inpatient and outpatient serious mental illness services must be provided by a network provider (see above-referenced benefits for plan limits).
- (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) At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member coinsurance required based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled.

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