HIGHMARK. PPOBlue
A Preferred-Provider Program

Summary of PPOBlue Value Plus 250 *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)	80% after deductible	60% after deductible
Out-of-Pocket Maximums (Once met, plan payment level becomes 100%)		
Individual	$2,500	$5,000
Family	$5,000	$10,000
Lifetime Maximum (per person)	Unlimited	$1,000,000
Primary Care Physician Office Visits	100% after $20 copayment	60% after deductible
Specialist Office Visits	100% after $20 copayment	60% after deductible
Preventive Care		
Adult		
Routine physical exams	100% after $20 copayment	Not Covered
Adult Immunizations	80% after deductible	60% after deductible
Routine gynecological exams, including a Pap Test	100% after $20 copayment	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	80% (deductible does not apply)	60% after deductible
Pediatric		
Routine physical exams	100% after $20 copayment	Not Covered
Pediatric immunizations	80% (deductible does not apply)	60% (deductible does not apply)
Emergency Room Services	80% (deductible does not apply)	
Spinal Manipulations	100% after $20 copayment	60% after deductible
	Limit: 20 visits/benefit period	
Physical Medicine	100% after $20 copayment	60% after deductible
	Limit: 20 visits/benefit period	
Speech Therapy	100% after $20 copayment	60% after deductible
	Limit: 20 visits/benefit period	
Occupational Therapy	100% after $20 copayment	60% after deductible
	Limit: 20 visits/benefit period	
Allergy Extracts and Injections	80% after deductible	60% after deductible
Ambulance	80% (deductible does not apply)	
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diabetes Treatment	80% after deductible	60% after deductible
Diagnostic Services (including routine)		
Advanced Imaging (MRI, CAT Scan, PET scan, etc.)	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible
Enteral Formulae	80% (deductible does not apply)	60% (deductible does not apply)
Home Infusion Therapy	100% after network deductible	
Home Health Care	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Hospital Services – Inpatient	80% after deductible	60% after deductible
Hospital Services – Outpatient	80% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment(2)	80% after deductible	60% after deductible
Maternity (facility & professional services)	80% after deductible	60% after deductible

Benefit	Network	Out-of-Network
Medical/Surgical Expenses (Except Office Visits)	80% after deductible	60% after deductible
Mental Health – Inpatient(3)	80% after deductible Limit: 30 days/benefit period	60% after deductible Limit: 10 days/benefit period
	Limit: 30 days/benefit period	
Mental Health – Outpatient(3)	100% after $20 copayment Limit: 20 visits/benefit period	60% after deductible Limit: 10 visits/benefit period
	Limit: 20 visits/benefit period	
Private Duty Nursing	80% after network deductible	
Respiratory Therapy	80% after network deductible	
Skilled Nursing Facility Care	80% after deductible	60% after deductible Limit: 100 days/benefit period
Substance Abuse – Inpatient Detoxification	80% after deductible	60% after deductible
	Limit: 7 days/admission; 4 admissions/lifetime	
Substance Abuse – Inpatient Rehabilitation	80% after deductible	60% after deductible
	Limit: 30 days/benefit period; 90 days/lifetime	
Substance Abuse – Outpatient	100% after $20 copayment	60% after deductible
	Limit: 60 visits/benefit period; 120 visits/lifetime	
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
Transplant Services	80% after deductible	60% after deductible
Precertification Requirements(4)	Yes	
Prescription Drug Deductible Individual Family	 $100 per Contract year $200 per Contract year	
Premier Prescription Drug Program	***Defined by Premier Pharmacy Network - Not Physician Network.*** ***(Prescriptions filled at a non-network pharmacy are not covered.)*** **Retail Drugs** Plan pays 80% after deductible $10 minimum member payment per prescription $50 maximum member payment per prescription **Mandatory Generic**(5) **31-day Supply** **Maintenance Drugs through Mail Order** Plan pays 80% after deductible $20 minimum member payment per prescription $100 maximum member payment per prescription **Mandatory Generic**(5) **90-day Supply**	

(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) 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.