

# Summary of PPOBlue 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.

## Municipal Employers Insurance Trust (MEIT)

Benefit	Network	Out-of-Network
<b>Benefit Period</b> Ⓛ	Calendar Year	
<b>Deductible</b> (per benefit period)		
Individual	None	\$250
Family	None	\$500
<b>Plan Payment Level</b> – Based on the provider's reasonable charge (PRC)	100%	80% after deductible until out-of-pocket maximum is met; then 100%
<b>Out-of-Pocket Maximums</b>		
Individual	Not Applicable	\$1,500
Family	Not Applicable	\$3,000
<b>Lifetime Maximum</b> (per person)	Unlimited	\$1,000,000
<b>Primary Care Physician Office Visits</b>	100% after \$10 copayment	80% after deductible Limit: 15 visits/benefit period
<b>Specialist Office Visits</b>	100% after \$10 copayment	80% after deductible Limit: 15 visits/benefit period
<b>Preventive Care</b>		
<i>Adult</i>		
Routine physical exams	100% after \$10 copayment	Not Covered
Adult Immunizations	100%	80% after deductible
Routine gynecological exams, including a PAP Test	100% after \$10 copayment	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	80% after deductible
<i>Pediatric</i>		
Routine physical exams	100% after \$10 copayment	Not Covered
Pediatric immunizations	100%	80% (deductible does not apply)
<b>Emergency Room Services</b>	100% after \$25 copayment (waived if admitted)	
<b>Spinal Manipulations</b>	100%	80% after deductible Limit: 25 visits/benefit period
<b>Physical Medicine</b>	100%	80% after deductible
<b>Speech Therapy</b>	100%	100% after deductible
<b>Occupational Therapy</b>	100%	100% after deductible
<b>Allergy Extracts and Injections</b>	100%	80% after deductible
<b>Ambulance</b>	100%	
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Dental Services Related to Accidental Injury</b>	100%	80% after deductible
<b>Diabetes Treatment</b>	100%	80% after deductible
<b>Diagnostic Services (including routine)</b>	100%	80% 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)	100%	80% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100%	100% after deductible
<b>Enteral Formulae</b>	100%	80% (deductible does not apply)
<b>Home Infusion Therapy</b>	100%	100% after deductible
<b>Home Health Care</b>	100%	100% Combined limit: 100 visits/benefit period
<b>Hospice</b>	100%	100% after deductible
<b>Hospital Services – Inpatient</b>	100%	80% after deductible
<b>Hospital Services – Outpatient</b>	100%	80% after deductible
<b>Infertility Counseling, Testing and Treatment</b> Ⓜ	100%	80% after deductible

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Maternity</b> (facility & professional)	100%	80% after deductible
<b>Medical/Surgical Expenses</b> (Except Office Visits)	100%	80% after deductible
<b>Mental Health – Inpatient</b> <sup>③</sup>	100% Limit: 30 days/benefit period	80% after deductible Limit: 10 days/benefit period
<b>Mental Health – Outpatient</b> <sup>③</sup>	100% after \$20 copayment Limit: 45 visits/benefit period	50% after deductible Limit: 15 visits/benefit period
<b>Private Duty Nursing</b>	100% Limit: \$20,000/calendar year	100%
<b>Respiratory Therapy</b>	100%	100% after deductible
<b>Skilled Nursing Facility Care</b>	100%	80% after deductible Limit: 100 days/benefit period
<b>Substance Abuse – Inpatient Detoxification</b>	100% Limit: 7 days/admission; 4 admissions/lifetime	80% after deductible
<b>Substance Abuse – Inpatient Rehabilitation</b>	100% Limit: 30 days/benefit period; 90 days/lifetime	80% after deductible
<b>Substance Abuse – Outpatient</b>	100% after \$10 copayment Limit: 60 visits/benefit period; 120 visits/lifetime	80% after deductible
<b>Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy & Dialysis)	100%	80% after deductible
<b>Transplant Services</b>	100%	80% after deductible
<b>Precertification Requirements</b>	Performed by Provider	Performed by Member <sup>④</sup>
<b>Prescription Drug Deductible</b> Individual Family		Per benefit period None None
<b>Premier Prescription Drug Program</b>	<p><b>Defined by Premier Gold Pharmacy Network - Not Physician Network.</b> <b>(Prescriptions filled at a non-network pharmacy are not covered.)</b></p> <p><b>Retail Drugs</b> \$5 copayment generic \$15 copayment brand – formulary<sup>⑤</sup> \$30 copayment brand – non-formulary Mandatory Generic<sup>⑥</sup> 31-day supply</p> <p><b>Maintenance Drugs through Mail Order</b> \$10 copayment generic \$30 copayment brand – formulary<sup>⑤</sup> \$60 copayment brand – non-formulary Mandatory Generic<sup>⑥</sup> 90-day Supply</p>	

- ① Your group's benefit period is based on a Calendar Year. The Calendar 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 Member is required to contact Highmark Health Care Management Services prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related admission. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.
- ⑤ The formulary is an extensive list of Food & 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.
- ⑥ The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand drug. The member payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or coinsurance amounts which may apply.

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