

Summary of PPOBlue Option III 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
Benefit Period Ⓛ	Calendar Year	
Deductible (per benefit period)		
Individual	None	\$250
Family	None	\$500
Plan Payment Level – Based on the provider's reasonable charge (PRC)	100%	80% after deductible until out-of-pocket maximum is met; then 100%
Out-of-Pocket Maximums		
Individual	Not Applicable	\$3,000
Family	Not Applicable	\$6,000
Lifetime Maximum (per person)	Unlimited	\$300,000
Primary Care Physician Office Visits	100% after \$10 copayment	80% after deductible
Specialist Office Visits	100% after \$10 copayment	80% after deductible
Preventive Care		
<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)
Emergency Room Services	100% after \$30 copayment (waived if admitted)	
Spinal Manipulations	100% after \$10 copayment Limit: 20 visits/benefit period	Not Covered
Physical Medicine	100% after \$10 copayment Limit: 20 visits/benefit period	Not Covered
Speech Therapy	100%	80% after deductible
Occupational Therapy	100%	80% after deductible
Allergy Extracts and Injections	100%	80% after deductible
Ambulance	100%	
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	100%	80% after deductible
Diabetes Treatment	100%	80% after deductible
Diagnostic Services (including routine)	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
Durable Medical Equipment, Orthotics and Prosthetics	100%	100% after deductible
Enteral Formulae	100%	80% (deductible does not apply)
Home Infusion Therapy	100%	
Home Health Care	100%	80% after deductible
Hospice	100%	80% after deductible
Hospital Services – Inpatient	100%	80% after deductible
Hospital Services – Outpatient	100%	80% after deductible
Infertility Counseling, Testing and Treatment Ⓜ	100%	80% after deductible
Maternity (facility & professional)	100%	80% after deductible
Medical/Surgical Expenses (Except Office Visits)	100%	80% after deductible

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

- ① Your group's benefit period is based on a Calendar Year.
- 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.