

## 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.

### County of Erie

Benefit	Network	Out-of-Network
<b>Benefit Period</b> (1)	Calendar Year	
<b>Deductible</b> (per benefit period)		
Individual	None	\$200
Family	None	\$400
<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> (Once met, plan payment level becomes 100%)		
Individual	None	\$2,000
Family	None	\$4,000
<b>Lifetime Maximum</b> (per person)	\$2,000,000	\$1,000,000
<b>Primary Care Physician Office Visits</b>	100% after \$15 copayment	80% after deductible Limit: 15 visits/calendar year
<b>Specialist Office Visits</b>	100% after \$15 copayment	80% after deductible
<b>Preventive Care</b>		
<i>Adult</i>		
Routine physical exams	100% after \$15 copayment	80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine gynecological exams, including a PAP Test	100% after \$15 copayment	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	80% after deductible
<i>Pediatric</i>		
Routine physical exams	100% after \$15 copayment	80% after deductible
Pediatric immunizations	100% (deductible does not apply)	80% (deductible does not apply)
<b>Emergency Room Services</b>	100% after \$25 copayment (waived if admitted)	
<b>Spinal Manipulations</b>	100% after \$15 copayment	80% after deductible
	Limit: 25 visits/benefit period	
<b>Physical Medicine</b>	100% after \$15 copayment Limit: 25 visits/calendar year	Not Covered
<b>Speech Therapy</b>	100% after \$15 copayment	80% after deductible
	Limit: 25 visits/benefit period	
<b>Occupational Therapy</b>	100% after \$15 copayment	80% after deductible
	Limit: 25 visits/benefit period	
<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>		
<i>Advanced Imaging</i> (MRI, CAT Scan, 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>Enteral Formulae</b>	100%	80% (deductible does not apply)
<b>Home Infusion Therapy</b>	100%	
<b>Home Health Care</b>	100%	80% after deductible
<b>Hospice</b>	100%	80% after deductible
<b>Hospital Services – Inpatient</b>	100%	80% after deductible
<b>Hospital Services – Outpatient</b>	100%	80% after deductible

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Maternity</b> (facility & professional services)	100%	80% after deductible
<b>Medical/Surgical Expenses</b> (Except Office Visits)	100%	80% after deductible
<b>Mental Health – Inpatient</b>	100%	80% after deductible
<b>Mental Health – Outpatient</b>	100% after \$15 copayment	80% after deductible
<b>Private Duty Nursing</b>	100%	80% after deductible
	Limit: \$20,000/calendar year	
<b>Respiratory Therapy</b>	100%	
<b>Skilled Nursing Facility Care</b>	100%	80% after deductible Limit: 100 days/benefit period
<b>Substance Abuse – Inpatient Detoxification</b>	100%	80% after deductible
<b>Substance Abuse – Inpatient Rehabilitation</b>	100%	80% after deductible
<b>Substance Abuse – Outpatient</b>	100% after \$15 copayment	80% after deductible
<b>Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
<b>Transplant Services</b>	100%	80% after deductible
<b>Precertification Requirements</b>	Performed by Provider	Performed by Member(2)
<b>Prescription Drug Deductible</b> Individual Family	Per Calendar Year None None	
<b>Premier Prescription Drug Program</b>	<i>Defined by Premier Gold Pharmacy Network - Not Physician Network. (Prescriptions filled at a non-network pharmacy are not covered.)</i> <b>Retail Drugs</b> \$12 generic copayment \$25 brand copayment <b>Mandatory Generic<sup>(3)</sup></b> <b>34-day Supply</b>  <b>Maintenance Drugs through Mail Order</b> \$24 generic copayment \$50 brand copayment <b>Mandatory Generic<sup>(3)</sup></b> <b>90-day Supply</b>	

**Questions? Call 1-800-215-7865**

**Reference Code: P0030203**

(Please have your Reference Code ready when you call)

- (1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
- (2) 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.
- (3) 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 contract of benefits. It is designed purely as a reference of the many benefits available under your program.*