

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.

Allegheny County

Standard Plan

Benefit	Network	Out-of-Network
Benefit Period (1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$200	\$4,500
Family	\$400	\$13,500
Plan Payment Level – Based on the provider's reasonable charge (PRC)	100% after deductible	50% after deductible until out-of-pocket maximum is met; then 100%
Out-of-Pocket Maximums (Once met, plan payment level becomes 100%)		
Individual	None	\$5,000
Family	None	\$15,000
Autism Spectrum Disorders Maximum (2)	\$36,000/benefit period	
Lifetime Maximum (per person)	Unlimited	\$1,000,000
Primary Care Physician Office Visits	100% after \$20 copayment	50% after deductible
Specialist Office Visits	100% after \$20 copayment	50% after deductible
Preventive Care		
Adult		
Routine physical exams	100% after \$20 copayment	Not Covered
Adult Immunizations	100% after deductible	50% after deductible
Colorectal Cancer Screening		
Diagnostic Services	100% after deductible	50% after deductible
Medical Surgical	100% after deductible	50% after deductible
Routine gynecological exams, including a PAP Test	100% after \$20 copayment	50% (deductible/lifetime maximum does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	50% after deductible
Pediatric		
Routine physical exams	100% after \$20 copayment	Not Covered
Pediatric immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Emergency Room Services	100% after \$75 copayment (waived if admitted)	
Spinal Manipulations	100% after \$20 copayment	50% after deductible
	Limit: 20 visits/benefit period	
Physical Medicine	100% after \$20 copayment	50% after deductible
Speech Therapy	100% after \$20 copayment	50% after deductible
Occupational Therapy	100% after \$20 copayment	50% after deductible
Allergy Extracts and Injections	100% after deductible	50% after deductible
Ambulance	100% after deductible	50% after deductible
Applied Behavior for Autism Spectrum Disorders (2)	100% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	100% after deductible	50% after deductible
Diabetes Treatment	100% after deductible	50% after deductible
Diagnostic Services (including routine)	100% after deductible	50% after deductible
Advanced Imaging (MRI, CAT Scan, PET scan, etc.)		
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	50% after deductible
Home Infusion Therapy	100% after deductible	50% after deductible
Home Health Care	100% after deductible	50% after deductible Limit: 100 days/calendar year
Hospice	100% after deductible	50% after deductible

Benefit	Network	Out-of-Network
Hospital Services – Inpatient	100% after deductible	50% after deductible
Hospital Services – Outpatient	100% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment⁽³⁾	100% after deductible	50% after deductible
Maternity (facility & professional services)	100% after deductible	50% after deductible
Medical/Surgical Expenses (Except Office Visits)	100% after deductible	50% after deductible
Mental Health – Inpatient⁽⁴⁾	100% after deductible	50% after deductible
Mental Health – Outpatient⁽⁴⁾	100% after \$20 copayment	50% after deductible
Private Duty Nursing	100% after deductible	50% after deductible
Respiratory Therapy	100% after deductible	50% after deductible
Skilled Nursing Facility Care	100% after deductible	50% after deductible
Substance Abuse – Inpatient Detoxification	100% after deductible	50% after deductible
Substance Abuse – Inpatient Rehabilitation	100% after deductible	50% after deductible
Substance Abuse – Outpatient	100% after \$20 copayment	50% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	50% after deductible
Transplant Services	100% after deductible	50% after deductible
Precertification Requirements	Performed by Provider	Performed by Member ⁽⁴⁾
Prescription Drug Deductible Individual Family	Per Calendar Year None None	
Premier Prescription Drug Program	<p><i>Defined by Premier Gold Pharmacy Network - Not Physician Network. (Prescriptions filled at a non-network pharmacy are not covered.)</i></p> <p>Retail Drugs \$5 copayment generic \$20 copayment brand-formulary⁽⁵⁾ \$45 copayment brand-non-formulary Mandatory Generic⁽⁶⁾ 30-day supply</p> <p>Maintenance Drugs through Mail Order \$10 copayment generic \$40 copayment brand-formulary⁽⁵⁾ \$90 copayment brand-non-formulary Mandatory Generic⁽⁶⁾ 90-day Supply</p>	

Questions? Call 1-800-215-7865

Reference Code: P0561009

(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) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
- (3) 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.
- (4) State mandated minimum benefits may apply to a diagnosis of serious mental illness. (If the above grid does not show a limit, your mental health benefit days and visits are unlimited).
- (5) 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.
- (6) 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.

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

01-Jan-2010 PPOBlue Allegheny County
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