

## 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**

**Groups: 17149-00 and subs**

**Wellness Rewards Plan**

Benefit	Network	Out-of-Network
<b>Benefit Period</b> (1)	Calendar Year	
<b>Deductible</b> (per benefit period)		
Individual	\$250	\$4,500
Family	\$500	\$13,500
<b>Plan Payment Level</b> – Based on the provider's reasonable charge (PRC)	100% after deductible	50% 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	\$5,000
Family	None	\$15,000
<b>Total Maximum Out of Pocket (includes deductible, coinsurance, copays, and other qualified medical expenses, in network only (8))</b>		
Individual	\$6,600	Not Applicable
Family	\$13,200	
<b>Autism Spectrum Disorders Maximum</b> (2)	\$40,000/benefit period	
<b>Lifetime Maximum</b> (per person)	Unlimited	Unlimited
<b>Primary Care Physician Office Visits</b>	100% after \$25 copayment	50% after deductible
<b>Specialist Office Visits</b>	100% after \$25 copayment	50% after deductible
<b>Preventive Care</b> (5)		
<i>Adult</i>		
Routine physical exams	100% (deductible does not apply)	Not Covered
Adult Immunizations	100% (deductible does not apply)	50% after deductible
Colorectal Cancer Screening Diagnostic Services	100% (deductible does not apply)	50% after deductible
Routine gynecological exams, including a PAP Test	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
<i>Pediatric</i>		
Routine physical exams	100% (deductible does not apply)	Not Covered
Pediatric immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
<b>Emergency Room Services</b>	100% after \$100 copayment (waived if admitted)	
<b>Spinal Manipulations</b>	100% after \$25 copayment	50% after deductible
	Limit: 20 visits/benefit period	
<b>Physical Medicine</b>	100% after \$25 copayment	50% after deductible
<b>Speech Therapy</b>	100% after \$25 copayment	50% after deductible
<b>Occupational Therapy</b>	100% after \$25 copayment	50% after deductible
<b>Allergy Extracts and Injections</b>	100% after deductible	50% after deductible
<b>Ambulance</b>	100% after deductible	50% after deductible
<b>Applied Behavior for Autism Spectrum Disorders</b> (2)	100% after deductible	50% after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Dental Services Related to Accidental Injury</b>	100% after deductible	50% after deductible
<b>Diabetes Treatment</b>	100% after deductible	50% after deductible
<b>Diagnostic Services (including routine)</b>	100% after deductible	50% 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% after deductible	50% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100% after deductible	50% after deductible

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Home Infusion Therapy</b>	100% after deductible	50% after deductible
<b>Home Health Care</b>	100% after deductible	50% after deductible Limit: 100 days/calendar year
<b>Hospice</b>	100% after deductible	50% after deductible
<b>Hospital Services – Inpatient</b>	100% after deductible	50% after deductible
<b>Hospital Services – Outpatient</b>	100% after deductible	50% after deductible
<b>Infertility Counseling, Testing and Treatment<sup>(3)</sup></b>	100% after deductible	50% after deductible
<b>Maternity</b> (facility & professional services)	100% after deductible	50% after deductible
<b>Medical/Surgical Expenses</b> (Except Office Visits)	100% after deductible	50% after deductible
<b>Mental Health – Inpatient<sup>(4)</sup></b>	100% after deductible	50% after deductible
<b>Mental Health – Outpatient<sup>(4)</sup></b>	100% after \$25 copayment	50% after deductible
<b>Private Duty Nursing</b>	100% after deductible	50% after deductible
<b>Respiratory Therapy</b>	100% after deductible	50% after deductible
<b>Skilled Nursing Facility Care</b>	100% after deductible	50% after deductible
<b>Substance Abuse – Inpatient Detoxification</b>	100% after deductible	50% after deductible
<b>Substance Abuse – Inpatient Rehabilitation</b>	100% after deductible	50% after deductible
<b>Substance Abuse – Outpatient</b>	100% after \$25 copayment	50% after deductible
<b>Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	50% after deductible
<b>Transplant Services</b>	100% after deductible	50% after deductible
<b>Precertification Requirements</b>	Performed by Provider	Performed by Member <sup>(6)</sup>
<b>Prescription Drug Deductible</b> Individual Family	Per Calendar Year None None	
<b>Premier Prescription Drug Program (7)</b>	<p><i>Defined by Premier Gold Pharmacy Network - Not Physician Network. (Prescriptions filled at a non-network pharmacy are not covered.)</i></p> <p><b>Retail Drugs</b> \$5 copayment generic \$20 copayment brand-formulary<sup>(7)</sup> \$50 copayment brand-non-formulary Mandatory Generic<sup>(7)</sup> 30-day supply</p> <p><b>Maintenance Drugs through Mail Order</b> \$10 copayment generic \$40 copayment brand-formulary<sup>(7)</sup> \$100 copayment brand-non-formulary Mandatory Generic<sup>(7)</sup> 90-day Supply</p>	

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

**Reference Code: P0200906**

- (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) Services are limited to those on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
- (6) 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.
- (7) 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. 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 insurance amounts which may apply.
- (8) Effective with plan years beginning on or after January 1, 2015, the Network Total Maximum Out-of-Pocket as mandated by the federal government must include deductible, coinsurance, copays, and any qualified medical expense. The Total Maximum Out of Pocket cannot be more than \$6,600 for individual and \$13,200 for two or more persons.

*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-2015 PPOBlue Allegheny County  
W-PPO