Summary of Benefits

This Summary of Benefits is a brief description of covered services. More details can be found in the Covered Services section.

Benefits	Network	Out-of-Network
General Provisions		
Benefit Period	Calendar Year	
Deductible (per benefit period) Individual Family	$250 $500	$500 $1,000
Plan Payment Level - Based on the provider's reasonable charge (PRC)	100% after deductible	80% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits Individual Family	None None	$1,500 $3,000
Lifetime Maximum (per member)	Unlimited	$1,000,000
Office Visits		
Primary Care Physician Office Visits[1]	100% after $10 copayment; deductible does not apply	80% after deductible
Specialist Office Visits	100% after $10 copayment; deductible does not apply	80% after deductible
Preventive Care Services		
Adult		
Routine physical exams	100% after $10 copayment; deductible does not apply	Not Covered
Adult Immunizations	100% after deductible	80% after deductible
Routine gynecological exams, including a PAP Test	100% after $10 copayment; deductible does not apply	80%; deductible and maximum do not apply
Mammograms, annual routine and medically necessary	100%; deductible does not apply	80% after deductible
Colorectal Cancer Screening, routine and medically necessary	100% after deductible	80% after deductible
Pediatric		
Routine physical exams	100% after $10 copayment; deductible does not apply	Not Covered
Pediatric immunizations	100%; deductible does not apply	80%; deductible and maximum do not apply
Emergency Room Services		
Emergency Room Services	100% after $35 copayment (waived if admitted as an inpatient); deductible does not apply	Same as network services
Hospital Services		
Hospital Services - Inpatient	100% after deductible	80% after deductible
Hospital Services - Outpatient[2]	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Spinal Manipulations	100% after $10 copayment; deductible does not apply	80% after deductible
	Combined Limit: 20 visits per benefit period	
Physical Medicine	100% after $10 copayment; deductible does not apply	80% after deductible
	Combined Limit: 20 visits per benefit period	
Speech Therapy	100% after $10 copayment; deductible does not apply	80% after deductible
	Combined Limit: 20 visits per benefit period	

Benefits	Network	Out-of-Network
Occupational Therapy	100% after $10 copayment; deductible does not apply	80% after deductible
	Combined Limit: 20 visits per benefit period	
Cardiac Rehabilitation, Chemotherapy, and Dialysis Treatment	100% after deductible	80% after deductible
Infusion Therapy	100% after deductible	80% after deductible
Radiation Therapy	100% after deductible	80% after deductible
Respiratory Therapy	100% after deductible	Same as network services
Diagnostic Services		
Diagnostic Services (including routine and pre-admission testing) (Lab, x-ray, allergy testing and other diagnostic medical tests)	100% after deductible	80% after deductible
Behavioral Health Services		
Mental Health Care Services - Inpatient[3]	100% after deductible	80% after deductible
Mental Health Care Services - Outpatient	100% after deductible	80% after deductible
Substance Abuse Services - Inpatient Detoxification	100% after deductible	80% after deductible
Substance Abuse Services - Inpatient Residential Treatment and Rehabilitation Services	100% after deductible	80% after deductible
Substance Abuse Services - Outpatient	100% after deductible	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Assisted Fertilization Treatment	Not Covered	
Ambulance	100% after deductible	Same as network services
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diabetes Treatment	100% after deductible	80% after deductible
Durable Medical Equipment	100% after deductible	80% after deductible
Enteral Formulae	100%; deductible does not apply	80%; deductible does not apply
Home Infusion Therapy	100% after deductible	Same as network services
Home Health Care[4]	100% after deductible	80% after deductible
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment[5]	100% after deductible	80% after deductible
Maternity (facility and professional services)	100% after deductible	80% after deductible
Orthotics	100% after deductible	80% after deductible
Pediatric Extended Care Services	100% after deductible	80% after deductible
	Combined Limit: 100 days per benefit period	
Private Duty Nursing	100% after deductible	Same as network services
Prosthetics	100% after deductible	80% after deductible
Skilled Nursing Facility Care	100% after deductible	80% after deductible
		Limit: 100 days per benefit period
Medical/Surgical Expenses (except office visits)	100% after deductible	80% after deductible
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements	Yes[6]	

[1] A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.

[2] Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.

[3] State-mandated minimum benefits 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 and delusional disorder. (If the above grid does not show a limit, your mental health benefit days and visits are unlimited.)

[4] The maternity home health care visit for network care is not subject to the program copayment, coinsurance or deductible amounts, if applicable. See Maternity Home Health Care Visit in the Covered Services section.

[5] If testing is required, cost sharing may apply as outlined under Diagnostic Services. 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.

[6] Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. 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.

Prescription Drug Benefits Benefits available through the Premier Pharmacy Network only. Mandatory Generic[1]	**Retail Pharmacy** Up to 31-day supply	**Maintenance Prescription Drugs through Mail Order** Up to 90-day supply
Generic Prescription Drug	$5 copayment	$10 copayment
Brand Formulary Prescription Drug[2]	$15 copayment	$30 copayment
Brand Non-Formulary Prescription Drug[2]	$30 copayment	$60 copayment

1 You are responsible for the payment differential when a generic drug is authorized by the physician and the patient purchases a brand name drug. Your 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.

2 The Highmark 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 and may, from time to time, be revised by the committee. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above.