

## Summary of Balance PPO \$1750 A Benefits

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

| Benefit  | Network  | Out-of-Network                  |
|--|--|---------------------------------|
| <b>General Provisions</b>  |  |                                 |
| <b>Benefit Period</b> <sup>(1)</sup>   | Contract Year  |                                 |
| <b>Deductible</b> (per benefit period)   |  |                                 |
| Individual   | \$1,750  | \$3,500                         |
| Family   | \$3,500  | \$7,000                         |
| <b>Plan Pays</b> – payment based on the plan allowance   | 90% after deductible   | 70% after deductible            |
| <b>Out-of-Pocket Limit</b> (Includes deductible, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period.)   |  |                                 |
| Individual   | \$6,350  | \$12,700                        |
| Family   | \$12,700   | \$25,400                        |
| <b>Office/Clinic/Urgent Care Visits</b>  |  |                                 |
| <b>Retail Clinic Visits</b>  | 100% after \$35 copayment  | 70% after deductible            |
| <b>Primary Care Provider Office Visits</b>   | 100% after \$35 copayment  | 70% after deductible            |
| <b>Specialist Office &amp; Virtual Visits</b>  | 100% after \$65 copayment  | 70% after deductible            |
| Virtual Visit Originating Site Fee   | 90% after deductible   | 70% after deductible            |
| <b>Urgent Care Center Visits</b>   | 100% after \$75 copayment  | 70% after deductible            |
| <b>Telemedicine Service</b> <sup>(2)</sup>   | 100% after \$20 copayment  |                                 |
| <b>Preventive Care</b> <sup>(3)</sup>  |  |                                 |
| <b>Routine Adult</b>   |  |                                 |
| Adult immunizations  | 100% (deductible does not apply)   | 70% after deductible            |
| Colorectal cancer screening  | 100% (deductible does not apply)   | 70% after deductible            |
| Diagnostic services and procedures   | 100% (deductible does not apply)   | 70% after deductible            |
| Mammograms, annual routine and medically necessary   | Routine: 100% (deductible does not apply)<br>Medically Necessary: 100% (deductible does not apply) | 70% after deductible            |
| Physical exams   | 100% (deductible does not apply)   | 70% after deductible            |
| Routine gynecological exams, including a Pap Test  | 100% (deductible does not apply)   | 70% (deductible does not apply) |
| Routine adult vision exam  | Not Covered  |                                 |
| <b>Routine Pediatric</b>   |  |                                 |
| Diagnostic services and procedures   | 100% (deductible does not apply)   | 70% after deductible            |
| Pediatric immunizations  | 100% (deductible does not apply)   | 70% (deductible does not apply) |
| Physical exams   | 100% (deductible does not apply)   | 70% after deductible            |
| <b>Pediatric Vision</b> <sup>(4)</sup> -<br><b>Davis Vision National Network</b>   |  |                                 |
| Exam (including dilation, as professionally indicated)   | 100% (deductible does not apply)   | Not Covered                     |
| Pediatric frame selection  | 100% (deductible does not apply)   | Not Covered                     |
| Standard eyeglass lenses (per pair)  | 100% (deductible does not apply)   | Not Covered                     |
| <b>Pediatric Dental</b> <sup>(4)</sup> -<br><b>United Concordia Advantage Network</b>  |  |                                 |
| Exam and Cleanings   | 100% (deductible does not apply)   | Not Covered                     |
| Basic Services (Fluoride treatments, sealants, consultations)  | 50% (deductible does not apply)  | Not Covered                     |
| Major Services (Radiographs (all x-rays), space maintainers, amalgam restorations (metal fillings), resin based composite fillings (white fillings), crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) | 50% (deductible does not apply)  | Not Covered                     |
| Orthodontics <sup>(5)</sup> (Medically necessary with prior approval. Waiting limits apply.)   | 50% (deductible does not apply)  | Not Covered                     |
| <b>Hospital and Medical/Surgical Expenses (including maternity)</b>  |  |                                 |
| <b>Hospital Inpatient</b>  | 90% after deductible   | 70% after deductible            |
| <b>Hospital Outpatient</b>   | 90% after deductible   | 70% after deductible            |
| <b>Maternity</b> (non-preventive facility & professional services) including dependent daughter  | 90% after deductible   | 70% after deductible            |
| <b>Medical Care</b> (including inpatient visits and consultations)/ <b>Surgical Expenses</b>   | 90% after deductible   | 70% after deductible            |

| Benefit   | Network  | Out-of-Network                  |
|---|--|---------------------------------|
| <b>Emergency Services</b>   |  |                                 |
| <b>Emergency Room Services</b>  | 100% after \$150 copayment (waived if admitted)  |                                 |
| <b>Ambulance</b>  | 90% after deductible   | 90% after in network deductible |
| <b>Ambulance – Non-Emergency</b>  | 90% after deductible   | 70% after deductible            |
| <b>Therapy, Rehabilitative and Habilitative Services</b>  |  |                                 |
| <b>Physical Medicine (Rehabilitative and Habilitative)</b>  | 100% after \$65 copayment  | 70% after deductible            |
|   | Limit: 30 combined rehab/habilitative visits/benefit period  |                                 |
| <b>Respiratory Therapy</b>  | 90% after deductible   | 70% after deductible            |
| <b>Speech &amp; Occupational Therapy (Rehabilitative and Habilitative)</b>  | 100% after \$65 copayment  | 70% after deductible            |
|   | Limit: 30 combined rehab/habilitative visits per therapy/benefit period  |                                 |
| <b>Spinal Manipulations</b>   | 100% after \$65 copayment  | 70% after deductible            |
|   | Limit: 20 visits/benefit period  |                                 |
| <b>Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)</b>   | 90% after deductible   | 70% after deductible            |
| <b>Mental Health/Substance Abuse</b>  |  |                                 |
| <b>Inpatient</b>  | 90% after deductible   | 70% after deductible            |
| <b>Inpatient Detoxification/Rehabilitation</b>  | 90% after deductible   | 70% after deductible            |
| <b>Outpatient</b>   | 100% after \$65 copayment  | 70% after deductible            |
| <b>Other Services</b>   |  |                                 |
| <b>Allergy Extracts and Injections</b>  | 90% after deductible   | 70% after deductible            |
| <b>Assisted Fertilization Procedures</b>  | Not Covered  | Not Covered                     |
| <b>Dental Services Related to Accidental Injury</b>   | Not Covered  |                                 |
| <b>Diagnostic Services</b>  |  |                                 |
| <i>Advanced Imaging (MRI, CAT, PET scan, etc.)</i>  | 100% after \$200 copayment   | 70% after deductible            |
| <i>Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</i>   | 100% after \$65 copayment  | 70% after deductible            |
| <b>Durable Medical Equipment, Orthotics and Prosthetics</b>   | 90% after deductible   | 70% after deductible            |
|   | 90% after deductible   | 70% after deductible            |
| <b>Home Health Care</b>   | Limit: 90 visits/benefit period  |                                 |
| <b>Hospice</b>  | 90% after deductible   | 70% after deductible            |
| <b>Infertility Counseling, Testing and Treatment<sup>(6)</sup></b>  | 90% after deductible   | 70% after deductible            |
| <b>Private Duty Nursing</b>   | 90% after deductible   | 70% after deductible            |
|   | Limit: 240 hours/benefit period  |                                 |
| <b>Skilled Nursing Facility Care</b>  | 90% after deductible   | 70% after deductible            |
|   | Limit: 120 days/benefit period   |                                 |
| <b>Transplant Services</b>  | 90% after deductible   | 70% after deductible            |
| <b>Precertification Requirements<sup>(7)</sup></b>  | YES  |                                 |
| <b>Prescription Drugs</b>   |  |                                 |
| <b>Prescription Drug Deductible</b><br>Individual<br>Family   | None<br>None   |                                 |
|   | <b>Retail Drugs (31/60/90-day Supply)</b><br>\$3 / \$6 / \$9 low cost generic copayment --- \$10 / \$20 / \$30 generic copayment<br>\$50 / \$100 / \$150 formulary brand copayment<br>\$85 / \$170 / \$255 non-formulary copayment |                                 |
| <b>Prescription Drug Program<sup>(8)</sup></b><br>Soft Mandatory Generic<br><i>Defined by the Premier 2012 Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i><br><br><i>Your plan uses the HCR Comprehensive Formulary with an Incentive Benefit Design.</i> | <b>Maintenance Drugs through Mail Order (90-day Supply)</b><br>\$8 low cost generic copayment -- \$25 standard generic copayment<br>\$125 formulary brand copayment<br>\$213 non-formulary brand copayment                         |                                 |

- (1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
- (2) Services must be performed by a Highmark approved telemedicine provider.
- (3) Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
- (4) Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.
- (5) A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality. Prior approval is required. 12 month waiting period required. See your benefit booklet for more details.
- (6) 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.
- (7) Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

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

(8) The formulary is an extensive list of Food and 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 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. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.