

# 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
<b>General Provisions</b>		
<b>Benefit Period<sup>1</sup></b>	Contract Year	
<b>Deductible (per benefit period)</b>		
Individual	None	\$500
Family	None	\$1,000
<b>Plan Payment Level - Based on the provider's reasonable charge (PRC)</b>	100%	80% after deductible until out-of-pocket limit is met; then 100%
<b>Out-of-Pocket Limits</b>		
Individual	None	\$3,000
Family	None	\$6,000
<b>Autism Spectrum Disorders maximum (per member)<sup>2</sup></b>	\$36,000 maximum per benefit period (Includes prescription drug expenses)	
<b>Lifetime Maximum (per member)</b>	Unlimited	
<b>Office Visits<sup>3</sup></b>		
<b>Primary Care Physician Office Visits<sup>4</sup></b>	100% after \$20 copayment	80% after deductible
<b>Specialist Office Visits</b>	100% after \$20 copayment	80% after deductible
<b>Preventive Care Services</b>		
<b>Adult</b>		
Routine physical exams	100% after \$20 copayment	Not Covered
Adult Immunizations	100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
Routine gynecological exams, including a PAP Test	100% after \$20 copayment	80%; deductible does not apply
Mammograms, annual routine and medically necessary	100%	80% after deductible
Colorectal Cancer Screening	100%	80% after deductible
<b>Pediatric</b>		
Routine physical exams	100% after \$20 copayment	Not Covered
Pediatric immunizations	100%	80%; deductible does not apply
Diagnostic services and procedures	100%	80% after deductible
<b>Emergency Room Services</b>		
<b>Emergency Room Services</b>	100% after \$50 copayment (waived if admitted as an inpatient)	Same as network services
<b>Hospital Services</b>		
<b>Hospital Services - Inpatient</b>	100%	80% after deductible
<b>Hospital Services - Outpatient<sup>5</sup></b>	100%	80% after deductible
<b>Therapy and Rehabilitation Services</b>		
<b>Spinal Manipulations</b>	100% after \$20 copayment	80% after deductible
	Combined Limit: 20 visits per benefit period	
<b>Physical Medicine</b>	100% after \$20 copayment	80% after deductible
	Combined Limit: 20 visits per benefit period	
<b>Speech Therapy</b>	100% after \$20 copayment	80% after deductible
	Combined Limit: 20 visits per benefit period	
<b>Occupational Therapy</b>	100% after \$20 copayment	80% after deductible
	Combined Limit: 20 visits per benefit period	

<b>Benefits</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Cardiac Rehabilitation, Chemotherapy, and Dialysis Treatment</b>	100%	80% after deductible
<b>Infusion Therapy</b>	100%	80% after deductible
<b>Radiation Therapy</b>	100%	80% after deductible
<b>Respiratory Therapy</b>	100%	100%; deductible does not apply
<b>Diagnostic Services</b>		
<b>Diagnostic Services (Lab, x-ray, allergy testing and other diagnostic medical tests)</b>	100%	80% after deductible
<b>Behavioral Health Services</b>		
<b>Mental Health Care Services - Inpatient<sup>6</sup></b>	100%	80% after deductible
<b>Mental Health Care Services - Outpatient</b>	100%	80% after deductible
<b>Substance Abuse Services - Inpatient Detoxification</b>	100%	80% after deductible
<b>Substance Abuse Services - Inpatient Residential Treatment and Rehabilitation Services</b>	100%	80% after deductible
<b>Substance Abuse Services - Outpatient</b>	100%	80% after deductible
<b>Other Services</b>		
<b>Allergy Extracts and Injections</b>	100%	80% after deductible
<b>Applied Behavior Analysis for Autism Spectrum Disorders (ASD)<sup>2</sup></b>	100%	80% after deductible
<b>Assisted Fertilization Treatment</b>	Not Covered	
<b>Ambulance</b>	100%	Same as network services
<b>Dental Services Related to Accidental Injury</b>	100%	80% after deductible
<b>Diabetes Treatment</b>	100%	80% after deductible
<b>Dr. Dean Ornish Program For Reversing Heart Disease<sup>7</sup></b>	100%	Same as network services
	Maximum of one enrollment per lifetime	
<b>Durable Medical Equipment</b>	100%	80% after deductible
<b>Enteral Formulae</b>	100%	80%; deductible does not apply
<b>Home Infusion Therapy</b>	100%	100%; deductible does not apply
<b>Home Health Care<sup>6</sup></b>	100%	80% after deductible
<b>Hospice</b>	100%	80% after deductible
<b>Infertility Counseling, Testing and Treatment<sup>9</sup></b>	100%	80% after deductible
<b>Maternity (facility and professional services)</b>	100%	80% after deductible
<b>Orthotics</b>	100%	80% after deductible
<b>Pediatric Extended Care Services</b>	100%	80% after deductible
	Combined Limit: 100 days per benefit period	
<b>Private Duty Nursing</b>	100%	100%; deductible does not apply
<b>Prosthetics</b>	100%	80% after deductible
<b>Skilled Nursing Facility Care</b>	100%	80% after deductible
		Limit: 100 days per benefit period
<b>Medical/Surgical Expenses (except office visits)</b>	100%	80% after deductible
<b>Transplant Services</b>	100%	80% after deductible
<b>Precertification Requirements</b>	Yes <sup>10</sup>	

**Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during a benefit period will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.**

- <sup>1</sup> Your group's benefit period is based on a contract year. The contract year is a consecutive 12-month period beginning on April 1.
- <sup>2</sup> Coverage for eligible members to age 21. Services will be paid according to the benefit category, i.e., speech therapy. Treatment for autism spectrum disorders does not reduce visit/day limits.
- <sup>3</sup> 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.
- <sup>4</sup> A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.
- <sup>5</sup> Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.
- <sup>6</sup> State-mandated minimum benefits apply to a diagnosis of serious mental illness. Serious mental illnesses include: schizophrenia, schizoaffective 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.)
- <sup>7</sup> The program may be subject to class size limits and is only offered at selected sites. Therefore, the availability of a Dr. Dean Ornish participating provider within a particular geographic area may be limited.
- <sup>8</sup> 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.
- <sup>9</sup> 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.
- <sup>10</sup> Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency 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.

<b>Prescription Drug Benefits</b> Benefits available through the Premier Pharmacy Network only.	<b>Retail Pharmacy</b> Up to 31/60/90-day supply	<b>Maintenance Prescription Drugs through Mail Order</b> Up to 90-day supply
<b>Mandatory Generic<sup>1</sup></b>		
<b>Generic Prescription Drug</b>	\$15/\$30/\$45 copayment	\$30 copayment
<b>Brand Prescription Drug</b>	\$30/\$60/\$90 copayment	\$60 copayment
<b>Selected Over-The-Counter Drugs With Written Prescription</b>	\$15 copayment	\$30 copayment

<sup>1</sup> Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your program. Under the mandatory generic provision, the member is responsible for the payment differential when a generic drug is available and the doctor or patient specifies a brand name drug. The member payment is the price difference between the brand and generic in addition to the copayment or coinsurance amounts, which may apply.