

Summary of Premier Balance PPO \$1000 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
	General Provisions Contract Year	
Benefit Period(1)	Contract	Year
Deductible (per benefit period)	#4.000	#2.000
Individual	\$1,000	\$2,000 \$4,000
Family	\$2,000	\$4,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes deductible, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period.)	0 0,000	# 0.400
Individual	\$3,200	\$6,400 \$13,800
Family	\$6,400	\$12,800
	e/Clinic/Urgent Care Visits	80% after deductible
Retail Clinic Visits	100% after \$20 copayment	
Primary Care Provider Office Visits	100% after \$20 copayment	80% after deductible
Specialist Office & Virtual Visits	100% after \$40 copayment	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after \$65 copayment	80% after deductible
Telemedicine Service(2)	100% after \$15	copayment
	Preventive Care(3)	
Routine Adult		000/ 6/
Adult immunizations	100% (deductible does not apply)	80% after deductible
Colorectal cancer screening	100% (deductible does not apply)	80% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)	80% after deductible
Physical exams	100% (deductible does not apply)	80% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Routine adult vision exam	Not Cov	
Routine Pediatric		
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
Pediatric immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Physical exams	100% (deductible does not apply)	80% after deductible
Pediatric Vision(4) - Davis Vision National Network		
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
Pediatric Dental(4) - United Concordia Advantage Network		
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(5) (Medically necessary with prior approval. Waiting limits apply.)	50% (deductible does not apply)	Not Covered
	I/Surgical Expenses (including maternity	
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	80% after deductible

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Limit: 20 visits/benefit period				
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Inpatient Detoxification/Rehabilitation Outpatient Outp		Substance Abuse		
Inpatient Detoxification/Rehabilitation		100% after deductible	80% after deductible	
Outpatient	ation/Rehabilitation		80% after deductible	
Allergy Extracts and Injections Assisted Fertilization Procedures Dental Services Related to Accidental Injury Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.) Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing) Durable Medical Equipment, Orthotics and Prosthetics Home Health Care Hospice Hospice Hospice Hospice United Duty Nursing Directility Counseling, Testing and Treatment(6) Directility Counseling, Testing and Treatment(6) Directility Counseling Skilled Nursing Facility Care Transplant Services Prescription Drug Deductible Individual Family Prescription Drug Program(8) Soft Mandatory Generic Defined by the Premier 2012 Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the HCR Comprehensive Formulary with Other Services 100% after deductible Not Covered 100% after \$100 capament 100% after deductible 80% after deductible 80% after deductible 100% after deductible 80% after deductible 100% after deductible 80% after deductible 80% after deductible 100% after deductible 100% after deductible 80% after deductible 100% after deductible 80% after deductible 80% after deductible 100% after deductible 80% after deductible 100% after deductible 100% after deductible 80% after deductible 80% after deductible 100% after deductible 100% after deductible 80% after deductible 80% after deductible 100% after deductible 80% after deductible 80% after deductible 100% after deductible 80% after deductible 80% after deductible 80% after deductible 80% after deductible 100% after deductible 80% after deductible 80			80% after deductible	
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(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.
 (8) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It
- (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.