Summary of Premier Balance PPO $3500 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		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $3,500 $7,000	 $7,000 $14,000
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.) Individual Family	 $6,350 $12,700	 $12,700 $25,400
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $45 copayment	80% after deductible
Primary Care Provider Office Visits	100% after $45 copayment	80% after deductible
Specialist Office & Virtual Visits	100% after $65 copayment	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $75 copayment	80% after deductible
Telemedicine Service(2)	100% after $20 copayment	
Preventive Care(3)		
Routine Adult		
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 Covered	
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
Hospital and Medical/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

Benefit	Network	Out-of-Network
Emergency Services		
Emergency Room Services	100% after $150 copayment (waived if admitted)	
Ambulance	100% after deductible	100% after in network deductible
Ambulance – Non-Emergency	100% after deductible	80% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Medicine (Rehabilitative and Habilitative)	100% after $65 copayment	80% after deductible
	Limit: 30 combined rehab/habilitative visits/benefit period	
Respiratory Therapy	100% after deductible	80% after deductible
Speech & Occupational Therapy (Rehabilitative and Habilitative)	100% after $65 copayment	80% after deductible
	Limit: 30 combined rehab/habilitative visits per therapy/benefit period	
Spinal Manipulations	100% after $65 copayment	80% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health/Substance Abuse		
Inpatient	100% after deductible	80% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	80% after deductible
Outpatient	100% after $65 copayment	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	Not Covered	
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after $200 copayment	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after $65 copayment	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	Limit: 90 visits/benefit period	
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment(6)	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	Limit: 120 days/benefit period	
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements(7)	YES	
Prescription Drugs		
Prescription Drug Deductible Individual Family	None None	
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 an Incentive Benefit Design.*	**Retail Drugs (31/60/90-day Supply)** $3 / $6 / $9 low cost generic copayment --- $10 /$20 / $30 generic copayment $50 / $100 / $150 formulary brand copayment $85 / $170 / $255 non-formulary copayment **Maintenance Drugs through Mail Order (90-day Supply)** $8 low cost generic copayment -- $25 standard generic copayment $125 formulary brand copayment $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.

(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.