



## Summary of Benefits

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period.

### Hoss's Steak and Sea House Group # 016405-01

Benefit	Network	Out-of-Network
<b>Benefit Period</b> (1)	Contract Year	
<b>Deductible</b> (per benefit period)		
Individual	\$250	\$500
Family	\$500	\$1,000
<b>Plan Payment Level</b> – Based on the provider's reasonable charge (PRC)	80% after deductible	60% after deductible
<b>Out-of-Pocket Maximums</b> (Once met, plan payment level becomes 100%)		
Individual	\$1,500	\$4,000
Family	\$3,000	\$8,000
<b>Autism Spectrum Disorders Maximum</b> (per person)(2)	\$36,000/benefit period	
<b>Lifetime Maximum</b> (per person)	Unlimited	\$1,000,000
<b>Primary Care Physician Office Visits</b>	100% after \$25 copayment	60% after deductible
<b>Specialist Office Visits</b>	100% after \$25 copayment	60% after deductible
<b>Preventive Care</b>		
<b>Adult</b>		
Routine physical exams	100% (deductible does not apply)	Not Covered
Adult Immunizations	80% after deductible	60% after deductible
Colorectal Cancer Screening		
Diagnostic Services	80% after deductible	60% after deductible
Medical Surgical	80% after deductible	60% after deductible
Routine gynecological exams, including a Pap Test	100% after \$25 copayment	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	60% after deductible
<b>Pediatric</b>		
Routine physical exams	100% (deductible does not apply)	Not Covered
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
<b>Emergency Room Services</b>	100% after \$100 copayment (waived if admitted)	
<b>Spinal Manipulations</b>	100% after \$25 copayment	60% after deductible
	Limit: 20 visits/benefit period	
<b>Physical Medicine</b>	100% after \$25 copayment	60% after deductible
	Limit: 20 visits/benefit period	
<b>Speech Therapy</b>	100% after \$25 copayment	60% after deductible
	Limit: 20 visits/benefit period	
<b>Occupational Therapy</b>	100% after \$25 copayment	60% after deductible
	Limit: 20 visits/benefit period	
<b>Allergy Extracts and Injections</b>	80% after deductible	60% after deductible
<b>Ambulance</b>	80% after network deductible	
<b>Applied Behavior Analysis for Autism Spectrum Disorders</b> (2)	80% after deductible	60% after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Dental Services Related to Accidental Injury</b>	80% after deductible	60% after deductible
<b>Diabetes Treatment</b>	80% after deductible	60% after deductible
<b>Diagnostic Services</b> (including routine)		
<b>Advanced Imaging</b> (MRI, CAT Scan, PET scan, etc.)	80% after deductible	60% after deductible
<b>Basic Diagnostic Services</b> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	80% after deductible	60% after deductible
<b>Enteral Formulae</b>	80% (deductible does not apply)	60% (deductible does not apply)
<b>Home Infusion Therapy</b>	80% after network deductible	
<b>Home Health Care</b>	80% after deductible	60% after deductible
<b>Hospice</b>	80% after deductible	60% after deductible
<b>Hospital Services – Inpatient</b>	80% after deductible	60% after deductible
<b>Hospital Services – Outpatient</b>	80% after deductible	60% after deductible
<b>Infertility Counseling, Testing and Treatment<sup>(3)</sup></b>	80% after deductible	60% after deductible
<b>Maternity (facility &amp; professional services)</b>	80% after deductible	60% after deductible
<b>Medical/Surgical Expenses (except office visits)</b>	80% after deductible	60% after deductible
<b>Mental Health – Inpatient<sup>(4)</sup></b>	80% after deductible	60% after deductible
<b>Mental Health – Outpatient<sup>(4)</sup></b>	100% after \$25 copayment	60% after deductible
<b>Private Duty Nursing</b>	80% after network deductible	
<b>Respiratory Therapy</b>	80% after network deductible	
<b>Skilled Nursing Facility Care</b>	80% after deductible	60% after deductible Limit: 100 days/benefit period
<b>Substance Abuse</b>		
Inpatient Detoxification	80% after deductible	60% after deductible
Inpatient Rehabilitation	80% after deductible	60% after deductible
Outpatient	100% after \$25 copayment	60% after deductible
<b>Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)</b>	80% after deductible	60% after deductible
<b>Transplant Services</b>	80% after deductible	60% after deductible
<b>Precertification Requirements<sup>(5)</sup></b>	Yes	
<b>Prescription Drug Deductible</b>		
Individual	\$100 per calendar year	
Family	\$200 per calendar year	
<b>Premier Prescription Drug Program</b>	<b>Retail Drugs (31-day Supply)</b>	
Mandatory Generic <sup>(6)</sup>	Plan pays 80% after deductible for generic prescriptions Plan pays 70% after deductible for brand prescriptions	
<i>Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered</i>	\$15 minimum copayment per prescription \$100 maximum copayment per prescription	
	<b>Maintenance Drugs through Mail Order (90-day Supply)</b>	
	Plan pays 80% after deductible for generic prescriptions Plan pays 70% after deductible for brand prescriptions	
	\$30 minimum copayment per prescription \$200 maximum copayment per prescription	

- (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) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
- (3) 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.
- (4) State mandated minimum benefits may apply to a diagnosis of serious mental illness. (If the above grid does not show a limit, your mental health benefit days and visits are unlimited.)
- (5) 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, you will be responsible for payment of any costs not covered.
- (6) 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 Highmark 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. You are responsible for the payment differential when a generic drug is authorized by your doctor 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.