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 # 016405-01,71

Benefit	Network	Out-of-Network
Benefit Period(1)	Contract Year	
Deductible (per benefit period)		
Individual	$350	$600
Family	$600	$1,100
Plan Payment Level – Based on the provider's reasonable charge (PRC)	75% after deductible	55% after deductible
Out-of-Pocket Maximums (Once met, plan payment level becomes 100%)		
Individual	$1,500	$4,000
Family	$3,000	$8,000
Autism Spectrum Disorders Maximum (per person)(2)	$36,000/benefit period	
Lifetime Maximum (per person)	Unlimited	
Primary Care Physician Office Visits	100% after $25 copayment	55% after deductible
Specialist Office Visits	100% after $50 copayment	55% after deductible
Preventive Care (3)		
Routine Adult		
Physical exams	100% (deductible does not apply)	Not Covered
Adult Immunizations	100% (deductible does not apply)	55% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	55% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	55% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	55% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	55% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	Not Covered
Pediatric immunizations	100% (deductible does not apply)	55% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	55% after deductible
Emergency Room Services	100% after $125 copayment (waived if admitted)	
Spinal Manipulations	100% after $50 copayment	55% after deductible
	Limit: 20 visits/benefit period	
Physical Medicine	100% after $50 copayment	55% after deductible
	Limit: 20 visits/benefit period	
Speech Therapy	100% after $50 copayment	55% after deductible
	Limit: 20 visits/benefit period	
Occupational Therapy	100% after $50 copayment	55% after deductible
	Limit: 20 visits/benefit period	
Allergy Extracts and Injections	75% after deductible	555% after deductible
Ambulance	75% after network deductible	
Applied Behavior Analysis for Autism Spectrum Disorders(2)	75% after deductible	55% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	75% after deductible	55% after deductible
Diabetes Treatment	75% after deductible	55% after deductible
Diagnostic Services (including routine) *Advanced Imaging* (MRI, CAT Scan, PET scan, etc.)	75% after deductible	55% after deductible

Benefit	Network	Out-of-Network
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	75% after deductible	55% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	75% after deductible	55% after deductible
Enteral Formulae	75% (deductible does not apply)	55% (deductible does not apply)
Home Infusion Therapy	75% after network deductible	
Home Health Care	75% after deductible	55% after deductible
Hospice	75% after deductible	55% after deductible
Hospital Services – Inpatient	75% after deductible	55% after deductible
Hospital Services – Outpatient	75% after deductible	55% after deductible
Infertility Counseling, Testing and Treatment(4)	75% after deductible	55% after deductible
Maternity (facility & professional services)	75% after deductible	55% after deductible
Medical/Surgical Expenses (except office visits)	75% after deductible	55% after deductible
Mental Health – Inpatient	75% after deductible	55% after deductible
Mental Health – Outpatient	75% after deductible	55% after deductible
Private Duty Nursing	75% after network deductible	
Respiratory Therapy	75% after network deductible	
Skilled Nursing Facility Care	75% after deductible	55% after deductible Limit: 100 days/benefit period
Substance Abuse		
Inpatient Detoxification	75% after deductible	55% after deductible
Inpatient Rehabilitation	75% after deductible	55% after deductible
Outpatient	75% after deductible	55% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	75% after deductible	55% after deductible
Transplant Services	75% after deductible	55% after deductible
Precertification Requirements(5)	Yes	
Prescription Drug Deductible Individual Family	 $100 per calendar year $200 per calendar year	
Premier Prescription Drug Program Mandatory Generic(6) *Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered*	**Retail Drugs (31-/60-/90 day Supply)** Plan pays 80% after deductible for generic prescriptions Plan pays 70% after deductible for brand prescriptions $15/$30/$45 minimum copayment per prescription $100/$200/$300 maximum copayment per prescription **Maintenance Drugs through Mail Order (90-day Supply)** 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.
(4) 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.
(3) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
(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.

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