



Summary of Out-of-Area PPO High Option II 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.

Pittsburgh Technology Council

Benefit	Network	Out-of-Network
Benefit Period Ⓢ	Contract Year	
Deductible (per benefit period)		
Individual	None	\$250
Family	None	\$500
Plan Payment Level – Based on the provider's reasonable charge (PRC)	100%	80% after deductible until out-of-pocket maximum is met; then 100%
Out-of-Pocket Maximums		
Individual	Not Applicable	\$2,000
Family	Not Applicable	\$4,000
Lifetime Maximum (per person)	Unlimited	\$1,000,000
Primary Care Physician Office Visits	100% after \$10 copayment	80% after deductible
Specialist Office Visits	100% after \$10 copayment	80% after deductible
Preventive Care		
<i>Adult</i>		
Routine physical exams	100% after \$10 copayment	Not Covered
Adult Immunizations	100%	80% after deductible
Routine gynecological exams, including a PAP Test	100% after \$10 copayment	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	80% after deductible
<i>Pediatric</i>		
Routine physical exams	100% after \$10 copayment	Not Covered
Pediatric immunizations	100%	80% (deductible does not apply)
Emergency Room Services	100% after \$35 copayment (waived if admitted)	
Spinal Manipulations	100% after \$10 copayment	80% after deductible
	Limit: 20 visits/benefit period	
Physical Medicine	100% after \$10 copayment	80% after deductible
	Limit: 20 visits/benefit period	
Speech Therapy	100% after \$10 copayment	80% after deductible
	Limit: 20 visits/benefit period	
Occupational Therapy	100% after \$10 copayment	80% after deductible
	Limit: 20 visits/benefit period	
Allergy Extracts and Injections	100%	80% after deductible
Ambulance	100%	
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	100%	80% after deductible
Diabetes Treatment	100%	80% after deductible
Diagnostic Services (including routine)	100%	80% after deductible
<i>Advanced Imaging</i> (MRI, CAT Scan, PET scan, etc.)		
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible
Enteral Formulae	100%	80% (deductible does not apply)
Home Infusion Therapy	100%	
Home Health Care	100%	
Hospice	100%	
Hospital Services – Inpatient	100%	80% after deductible
Hospital Services – Outpatient	100%	80% after deductible
Infertility Counseling, Testing and	100%	80% after deductible

Benefit	Network	Out-of-Network
Treatment ^②		
Maternity (facility & professional)	100%	80% after deductible
Medical/Surgical Expenses (Except Office Visits)	100%	80% after deductible
Mental Health – Inpatient ^③	100% Limit: 30 days/benefit period	80% after deductible Limit: 10 days/benefit period
Mental Health – Outpatient ^③	100% after \$10 copayment Limit: 20 visits/benefit period	80% after deductible Limit: 10 visits/benefit period
Private Duty Nursing		100%
Respiratory Therapy		100%
Skilled Nursing Facility Care	100%	80% after deductible Limit: 100 days/benefit period
Substance Abuse – Inpatient Detoxification	100% Limit: 7 days/admission; 4 admissions/lifetime	80% after deductible
Substance Abuse – Inpatient Rehabilitation	100% Limit: 30 days/benefit period; 90 days/lifetime	80% after deductible
Substance Abuse – Outpatient	100% after \$10 copayment Limit: 60 visits/benefit period; 120 visits/lifetime	80% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy & Dialysis)	100%	80% after deductible
Transplant Services	100%	80% after deductible
Precertification Requirements	Performed by Member ^④	
Prescription Drug Deductible	Per benefit period	
Individual	None	
Family	None	
Premier Prescription Drug Program	<p>Defined by Premier Gold Pharmacy Network - Not Physician Network. (Prescriptions filled at a non-network pharmacy are not covered.)</p> <p>Retail Drugs \$10 copayment generic \$20 copayment brand Mandatory Generic^⑤ 31-day supply</p> <p>Maintenance Drugs through Mail Order \$20 copayment generic \$40 copayment brand Mandatory Generic^⑤ 90-day Supply</p>	

- 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 renewal date. Contact your employer to determine the renewal date applicable to your program.
- ② 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 State mandated benefits (30 inpatient days and 60 outpatient visits annually with the right to exchange inpatient days for outpatient visits on a one-for-two basis) may apply to a diagnosis of serious mental illness. Serious mental illnesses include: schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa, delusional disorder. Once mental health limits are exhausted, both inpatient and outpatient serious mental illness services must be provided by a network provider (see above-referenced benefits for plan limits).
- ④ Member is required to contact Highmark Health Care Management Services prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related admission. 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.
- ⑤ Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. 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 drug and the generic drug in addition to the brand drug copayment or coinsurance amounts which may apply.