

# Summary of PPO Benefits



A PPO, or Preferred Provider Organization, offers two levels of benefits. 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.

## ICUBA

## Risk Reward

Benefit	In-Network	Out-of-Network
<b>Deductible</b>	\$1,500 Individual \$4,500 Family	\$3,000 Individual \$9,000 Family
<b>Coinsurance</b>	80%	60%
<b>Out-of-Pocket Maximums</b> (includes deductible)	\$3,500 Individual \$7,000 Family	\$7,000 Individual \$14,000 Family
<b>Lifetime Maximum</b>	\$2,000,000	
<b>Physician Office Visits</b> (General Practice, Internal Medicine, Family Practice, Pediatrician)	80% (not subject to deductible)	60% after deductible
<b>Specialist Office Visits</b>	80% (not subject to deductible)	60% after deductible
<b>Preventive Care</b> ① (Preventive guidelines apply; See schedule) Adult & Pediatric routine exams	80% (not subject to deductible)	Not Covered
Routine PAP tests	100% (not subject to deductible)	Not Covered
Prostate cancer screenings (PSA)	100% (not subject to deductible)	Not Covered
Routine mammograms	100% (not subject to deductible)	Not Covered
Routine Urinalysis	100% (not subject to deductible or copayment)	Not Covered
Routine General Health Panel	100% (not subject to deductible or copayment)	Not Covered
Routine pediatric immunizations	100% (not subject to deductible)	Not Covered
Routine diagnostic screenings and routine immunizations	100% (not subject to deductible)	Not Covered
<b>Allergy Injections</b>	80% (not subject to deductible)	60% after deductible
<b>Emergency Room Services</b> ②	100% after \$100 copayment (waived if admitted)	
<b>Ambulance</b>	80% after network deductible	
<b>Inpatient Hospital Expenses</b> ③	80% after deductible	60% after deductible
<b>Outpatient Hospital Expenses</b>	80% after deductible	60% after deductible
<b>Outpatient Surgery</b>		
Office Setting (Physician or Specialist)	80% (not subject to deductible)	60% after deductible
Outpatient Facility	80% after deductible	60% after deductible
Related professional services	80% after deductible	60% after deductible
<b>Infertility Services</b> (counseling and testing to diagnose)	80% after deductible	60% after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Outpatient Physical Medicine</b>	80% (not subject to deductible)	60% after deductible
	Limit: 30 visits/ benefit period	
<b>Outpatient Speech Therapy</b> (Restorative services only)	80% (not subject to deductible)	60% after deductible
	Limit: 30 visits/ benefit period	
<b>Outpatient Occupation Therapy</b>	80% (not subject to deductible)	60% after deductible
	Limit: 30 visits/ benefit period	

<b>Benefit</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Spinal Manipulation</b>	80% (not subject to deductible)	60% after deductible
	Limit: 60 visits/ benefit period	
<b>Diagnostic Services</b> (Lab, X-Ray and other tests)	80% after deductible	60% after deductible
<b>Outpatient Diagnostic Imaging</b> (MRI, MRA, CAT Scan, PET scan)	80% after deductible	60% after deductible
<b>Durable Medical Equipment</b>	80% after deductible	60% after deductible
	Limit: \$3,500/ benefit period	
<b>Prosthetic Appliances</b>	80% after deductible	60% after deductible
<b>Hearing Care Services</b> Hearing aid screening/exam Hearing aid	80% (not subject to deductible) 80% after deductible	60% after deductible 60% after deductible
	Combined limit: \$1,500/ benefit period	
<b>Temporomandibular Joint Disorder</b> (Medical necessity required; excludes appliances and orthodontic treatment)	80% after deductible	60% after deductible
<b>Inpatient Care at Other Health Care Facilities</b> <sup>③</sup> (Skilled Nursing, Rehabilitation)	80% after deductible	60% after deductible
	Limit: 60 visits/ benefit period	
<b>Home Health Care</b>	80% after deductible	60% after deductible
<b>Private Duty Nursing</b>	80% after deductible	60% after deductible
<b>Hospice</b> (Inpatient and Outpatient Care)	80% after deductible	60% after deductible
<b>Mental Health</b> Inpatient <sup>③</sup>	80% after deductible	60% after deductible
	Limit: 30 days / benefit period	
Outpatient	80% (not subject to deductible)	60% after deductible
	Limit: 20 visits/ benefit period	
<b>Substance Abuse</b> Inpatient <sup>③</sup> Rehabilitation & Detoxification	80% after deductible	60% after deductible
	Limit: 30 days/ benefit period	
Outpatient	80% (not subject to deductible)	60% after deductible
	Limit: 20 visits/ benefit period	
<b>Premier Prescription Drug Program</b> <sup>④</sup> (Defined by Premier Gold III Pharmacy Network)	\$10 copayment generic \$25 copayment brand formulary \$50 copayment brand non-formulary 30-day supply	60% (not subject to deductible)
<b>Mail Order Prescription Drug Program</b>	\$20 copayment generic \$50 copayment brand formulary \$100 copayment brand non-formulary 90-day supply	

## **Questions? Call 1-866-470-2963**

### **NOTE: Program reimbursement is based on provider's reasonable charge**

- ① Eligible preventive diagnostic services include, but are not limited to, PAP test, mammogram, ECG, EKG, colonoscopy, and bone density screening. Refer to the Preventive Schedule for the current guidelines regarding preventive care for you and your family.
- ② Urgent Care services rendered in a non-hospital setting will be payable 80% (not subject to deductible); Urgent Care services rendered in the Emergency Room setting will be subject to the Emergency Room copayment.
- ③ Pre-certification is required prior to all planned inpatient admissions, including Mental Health and Substance Abuse care. Notification should be provided to Blue Cross Blue Shield Health Care Management Services within 48 hours of an emergency or maternity-related admission. Please note that in most cases, in-network providers will obtain pre-certification on behalf of the patient. However, you will be responsible for obtaining pre-certification for Out of Network admissions. 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.
- ④ The formulary is an extensive list of Food & 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.

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