Summary of PPO *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.

Vibra Healthcare A

Benefit	Network	Out-of-Network
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $250 $750	 $300 $900
Plan Payment Level – Based on the provider's reasonable charge (PRC)	90% after deductible	70% after deductible
Out-of-Pocket Maximums (Once met, plan payment level becomes 100%) Individual Family	 $500 $1,500	 $2,000 $6,000
Lifetime Maximum (per person)	$1,000,000	
Primary Care Physician Office Visits	100% after $25 copayment	70% after deductible
Specialist Office Visits	100% after $35 copayment	70% after deductible
Preventive Care ***Adult*** Routine physical exams	 100% after $15 copayment	 70% after deductible
Adult Immunizations	100% no deductible	70% after deductible
Colorectal Cancer Screening	100% no deductible	70% after deductible
Routine gynecological exams, including a Pap Test	100% after $15 copayment no deductible/lifetime maximum	70% no deductible/lifetime maximum
Mammograms, annual routine and medically necessary	100% no deductible	70% after deductible
Pediatric Routine physical exams	 100% after $15 copayment	 70% after deductible
Pediatric immunizations	100% no deductible/lifetime maximum	70% no deductible/lifetime maximum
Emergency Room Services	100% after $125 copayment (waived if admitted)	
Spinal Manipulations	100% after $35 copayment	70% after deductible
	Limit: 20 visits/benefit period	
Physical Medicine	100% after $35 copayment	70% after deductible
	Limit: 30 visits/benefit period	
Speech Therapy & Occupational Therapy	100% after $35 copayment	70% after deductible
	Limit: 30 visits/benefit period	
Allergy Extracts and Injections	90% after deductible	70% after deductible
Ambulance	90% after deductible	70% after deductible
Assisted Fertilization Procedures	Not Covered	
Bariatric Services	Blue Distinction Centers 90%; Other Network Providers 70% up to Out of Pocket; 100% Thereafter	70% after deductible
Dental Services Related to Accidental Injury	Not Covered	
Diabetes Treatment	90% after deductible	70% after deductible
Diagnostic Services (including routine) ***Advanced Imaging*** (MRI, CAT Scan, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	70% after deductible
Enteral Formulae	90% (deductible does not apply)	70% (deductible does not apply)
Home Infusion Therapy	90% after deductible	70% after deductible
Home Health Care	90% after deductible	70% after deductible
	Limit: 90 visits/benefit period	

Benefit	Network	Out-of-Network
Hospice	90% after deductible	70% after deductible
Hospital Services – Inpatient	90% after deductible	70% after deductible
Hospital Services – Outpatient	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment(2)	90% after deductible	70% after deductible
Maternity (facility & professional services)	90% after deductible	70% after deductible
Medical/Surgical Expenses (except office visits)	90% after deductible	70% after deductible
Mental Health – Inpatient(3)	90% after deductible	70% after deductible
Mental Health – Outpatient(3)	100% after $35 copayment	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
	Limit: 240 hours/benefit period	
Respiratory Therapy	90% after deductible	70% after deductible
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	Limit: 100 days/benefit period	
Substance Abuse		
Inpatient Detoxification	90% after deductible	70% after deductible
Inpatient Rehabilitation	90% after deductible	70% after deductible
Outpatient	100% after $35 copayment	70% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements(4)	Yes	

(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) 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 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.)

(4) 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.