HIGHMARK. | PPO Blue

PPO Blue Benefit Summary - Basic Plan – Effective 1-1-18

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 None None	 $2,000 $4,000
Plan Pays – payment based on the plan allowance	100%	60% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 $5,000 $15,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $7,350 $14,700	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $20 copay	60% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $20 copay	60% after deductible
Specialist Office Visits & Virtual Visits	100% after $20 copay	60% after deductible
Virtual Visit Originating Site Fee	100%	60% after deductible
Urgent Care Center Visits	100% after $20 copay	60% after deductible
Telemedicine Services (3)	100% after $20 copay	Not Covered
Preventive Care (4)		
Routine Adult Physical Exams	 100%	 60% after deductible
Adult Immunizations	100%	60% after deductible
Routine Gynecological Exams, including a Pap Test	100%	60% (deductible does not apply)
Mammograms, Annual Routine	100%	60% after deductible
Mammograms, Medically Necessary	100%	60% after deductible
Diagnostic Services and Procedures	100%	60% after deductible
Routine Pediatric Physical Exams	 100%	 60% after deductible
Pediatric Immunizations	100%	60% (deductible does not apply)
Diagnostic Services and Procedures	100%	60% after deductible
Emergency Services		
Emergency Room Services	100% after $75 copay (waived if admitted)	
Ambulance – Emergency	100% no deductible	
Ambulance – Non-Emergency	100%	60% after deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	100% Limit: 365 days/2 pint blood deductible/benefit period	60% after deductible
Hospital Outpatient	100%	60% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100%	60% after deductible
Medical Care (including inpatient visits and consultations)	100%	60% after deductible
Surgical Expenses (except office visits) Includes Assistant Surgery, Anesthesia, Sterilization, Reversal Procedures, Neonatal Circumcision and Gender Reassignment Surgery	100%	60% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% Limit: 20 visits/benefit period	60% after deductible
Respiratory Therapy	100%	60% after deductible
Speech and Occupational Therapy	100%	60% after deductible

Benefit	In Network	Out of Network
	Limit: 12 visits/benefit period	
Spinal Manipulations	100%	60% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	60% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100%	60% after deductible
Inpatient Detoxification / Rehabilitation	100%	60% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100%	60% after deductible
Outpatient Substance Abuse Services	100%	60% after deductible
Other Services		
Allergy Extracts and Injections	100%	60% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	100%	60% after deductible
	$36,000 maximum/benefit period	
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	Not Covered	Not Covered
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	60% after deductible
Hearing Care Services	Not Covered	Not Covered
Home Health Care	100%	60% after deductible
	Limit: 90 visits/benefit period	
Hospice	100%	60% after deductible
Infertility Counseling, Testing and Treatment (6)	100%	60% after deductible
Private Duty Nursing	100%	60% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100%	60% after deductible
	Limit: 100 days/benefit period	
Transplant Services	100%	60% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible	None	
Prescription Drug Program (8) Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Refill for both Retail and Mail Order should be filled when 75% of medication has been used. Fertility Agents covered with Prior Authorization Your plan uses the Comprehensive Formulary with an Incentive Benefit Design Exclusive Pharmacy Provider does not apply. Managed RX Coverage on selected prescription drugs does not apply.	**Retail Drugs (30-day Supply)** $10 generic copay $30 formulary brand copay $45 non-formulary brand copay Mandatory Mail Order – initial prescription and one refill; then mail order **Maintenance Drugs through Mail Order (90-day Supply)** $10 generic copay $40 formulary brand copay $80 non-formulary brand copay Out of Pocket Maximum - $1,000 Individual	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(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) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. Effective with plan years beginning on or after January 1, 2018, the TMOOP cannot exceed $7,350 for individual and $14,700 for two or more persons.

(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health/Substance Abuse benefit.

(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.

(5) 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. If the ASD benefit period dollar maximum applies, only non-essential health benefits will accumulate.

(6) 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.

(7) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. 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.