HIGHMARK. Performance Flex Blue PPO

PPO

Intermediate Unit #1 Summary of Performance Flex Blue PPO *Benefits*

With Performance Flex Blue PPO, there are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers who offer enhanced benefits coverage, you will pay less out of pocket. 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.

Intermediate Unit #1 **Bronze Plan** 7/1/2021

Benefit	**Enhanced Value**	**Standard Value**	**Out-of-Network**
General Provisions			
Benefit Period(1)	Contract Year		
Deductible (per benefit period) (All in-network services are credited to both the enhanced and the standard deductibles.) Individual Family	 $3,000 $6,000	 $5,000 $10,000	 $10,000 $20,000
Plan Pays – payment based on the plan allowance	70% after deductible	60% after deductible	50% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% coinsurance for the rest of the benefit period) (All in-network services are credited to both the enhanced and the standard out-of-pocket limits.) Individual Family	 $1,200 $2,400	 $2,400 $4,800	 $20,000 $40,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (7) Once met, the plan pays 100% of covered services for the rest of the benefit period Individual Family	 $8,150 $16,300		 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	70% after deductible	60% after deductible	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	70% after deductible	60% after deductible	50% after deductible
Specialist Office Visits & Virtual Visits	70% after deductible	60% after deductible	50% after deductible
Virtual Visit Provider Originating Site Fee	70% after deductible	60% after deductible	50% after deductible
Urgent Care Center Visits	70% after deductible	60% after deductible	50% after deductible
Telemedicine Services (6)	70% after deductible		Not Covered
Preventive Care(2)			
Routine Adult			
Physical exams	100% (deductible does not apply)		50% after deductible
Adult immunizations	100% (deductible does not apply)		50% after deductible
Colorectal cancer screening	100% (deductible does not apply)		50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)		50% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)		50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Routine Pediatric			
Physical exams	100% (deductible does not apply)		50% after deductible
Pediatric immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Inpatient	70% after deductible	60% after deductible	50% after deductible
Hospital Outpatient	70% after deductible	60% after deductible	50% after deductible

Benefit	Enhanced Value	Standard Value	Out-of-Network
Maternity (non-preventive facility & professional services) including dependent daughter	70% after deductible	60% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/**Surgical Expenses**	70% after deductible	60% after deductible	50% after deductible
Emergency Services			
Emergency Room Services	70% after $100 copayment (waived if admitted)		
Ambulance	70% after network deductible		
Ambulance – Non-Emergency	70% after network deductible		
Therapy and Rehabilitation Services			
Physical Medicine	70% after deductible	60% after deductible	50% after deductible
	Limit: 20 visits/benefit period		
Respiratory Therapy	70% after deductible	60% after deductible	50% after deductible
Speech & Occupational Therapy	70% after deductible	60% after deductible	50% after deductible
	Limit: 20 visits/benefit period		
Spinal Manipulations	70% after deductible	60% after deductible	50% after deductible
	Limit: 20 visits/benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	70% after deductible	60% after deductible	50% after deductible
Mental Health/Substance Abuse			
Inpatient Mental Health Services	70% after enhanced deductible		50% after deductible
Inpatient Detoxification/Rehabilitation	70% after enhanced deductible		50% after deductible
Outpatient Mental Health Services – Includes Virtual Behavioral Visits	70% after enhanced deductible		50% after deductible
Outpatient Substance Abuse	70% after enhanced deductible		50% after deductible
Other Services			
Allergy Extracts and Injections	70% after deductible	60% after deductible	50% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (8)	70% after deductible	60% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered	Not Covered
Dental Services Related to Accidental Injury	Not Covered	Not Covered	Not Covered
Diagnostic Services			
Advanced Imaging (MRI, CAT, PET scan, etc.)	70% after deductible	60% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	70% after deductible	60% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	70% after deductible	60% after deductible	50% after deductible
Home Health Care	70% after deductible	60% after deductible	50% after deductible
	Benefit Limit: 90 visits/benefit period		
Hospice	70% after enhanced deductible		50% after deductible
Infertility Counseling, Testing and Treatment(3)	70% after deductible	60% after deductible	50% after deductible
Private Duty Nursing	70% after enhanced deductible		50% after deductible
	Benefit Limit: 240 hours/benefit period		
Skilled Nursing Facility Care	70% after deductible	60% after deductible	50% after deductible
	Benefit Limit: 100 days/benefit period		
Transplant Services	70% after enhanced deductible		50% after deductible
Precertification Requirements(4)	YES		
Prescription Drugs			
Prescription Drug Deductible Individual Family	Integrated with medical deductible Integrated with medical deductible		
Prescription Drug Program(5) *Defined by the **Advantage Pharmacy Network** - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary*	**Retail Drugs (31/60/90-day supply)** You pay 30% after deductible **Maintenance Drugs through Mail Order** (**90-day Supply)** You pay 30% after deductible		

Questions? Call 1-800-215-7865
Reference Code: P0030521
(Please have your Reference Code ready when you call.)

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning July 1st and ending June 30th.
(2) 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.
(3) 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.
(4) Be sure your provider is aware that Highmark Utilization Management must be contacted for authorization prior to a planned inpatient admission or within 48 hours of an emergency or unplanned inpatient admission. Also note that certain outpatient procedures require prior authorization. If authorization is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate you will be responsible for the payment of ant costs not covered by your health plan.

The terms "enhanced value" and "standard value" are not descriptors of the provider's ability. This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.

(5) At retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for our prescription drug at the discounted rate Highmark has negotiated. The amount
You paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled.
Your plan requires that you use Alliance Rx Walgreens Prime or Giant Eagle specialty pharmacies for select specialty medications. To obtain medications for hemophilia, you must use a specific pharmacy, please contact member services for more details.

(6) 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.

(7) 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.

(8) Coverage for eligible members to age 21. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum does not reduce visit/day limits.

Network services for outpatient occupational therapy, physical medicine and spinal manipulations will require authorization after 8 visits per benefit period. Your network provider will submit the request for authorization if additional visits are needed to continue your treatment plan but not to exceed your health care program visit limit. If an authorization is not obtained you would not be financially liable unless you chose to receive the service after being informed that it would not be covered or if you signed a waiver of pre-service denial form supplied by your provider.