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 — 7/1/2021

Benefit	Enhanced Value	Standard Value	Out-of-Network
General Provisions			
Benefit Period(1)	Contract Year		
Deductible (per benefit period) Individual Family	 None None	 $1,000 $2,000	 $2,000 $4,000
Plan Pays – payment based on the plan allowance	100%	80% after deductible	60% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period) Individual Family	 None None	 $2,000 $4,000	 $5,000 $10,000
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	100% after $5 copayment	100% after $40 copayment	60% after deductible
Primary Care Provider Office Visits & Virtual Visits	100%	100% after $20 copayment	60% after deductible
Specialist Office Visits & Virtual Visits	100% after $10 copayment	100% after $40 copayment	60% after deductible
Virtual Visit Provider Originating Site Fee	100%	80% after deductible	60% after deductible
Urgent Care Center Visits	100% after $20 copayment	100% after $40 copayment	60% after deductible
Telemedicine Services (6)	100%		Not Covered
Preventive Care(2)			
Routine Adult			
Physical exams	100% (deductible does not apply)	100% (deductible does not apply)	60% after deductible
Adult immunizations	100% (deductible does not apply)	100% (deductible does not apply)	60% after deductible
Colorectal cancer screening	100% (deductible does not apply)	100% (deductible does not apply)	60% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	100% (deductible does not apply)	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)	60% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	100% (deductible does not apply)	60% after deductible
Routine Pediatric			
Physical exams	100% (deductible does not apply)	100% (deductible does not apply)	60% after deductible
Pediatric immunizations	100% (deductible does not apply)	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	100% (deductible does not apply)	60% after deductible
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Inpatient	100%	80% after deductible	60% after deductible
Hospital Outpatient	100%	80% after deductible	60% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100%	80% after deductible	60% after deductible
Medical Care (including inpatient visits and consultations)/**Surgical Expenses**	100%	80% after deductible	60% after deductible
Emergency Services			
Emergency Room Services	100% after $100 copayment (waived if admitted)		
Ambulance	100%		

Benefit	Enhanced Value	Standard Value	Out-of-Network
Ambulance – Non-Emergency	100%		
Therapy and Rehabilitation Services			
Physical Medicine	100%	100% after $50 copayment	60% after deductible
Respiratory Therapy	100%	80% after deductible	60% after deductible
Speech & Occupational Therapy	100%	100% after $50 copayment	60% after deductible
Spinal Manipulations	100% after $20 copayment	100% after $50 copayment	60% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible	60% after deductible
Mental Health/Substance Abuse			
Inpatient Mental Health Services	100%	100%	60% after deductible
Inpatient Detoxification/Rehabilitation	100%	100%	60% after deductible
Outpatient Mental Health Services – Includes Virtual Behavioral Health Visits	100%	100%	60% after deductible
Other Services			
Allergy Extracts and Injections	100%	80% after deductible	60% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (8)	100%	80% after deductible	60% after deductible
Assisted Fertilization Procedures	100%	80% after deductible	60% after deductible
	$5,000 Family Maximum per Lifetime		
Dental Services Related to Accidental Injury	100%	80% after deductible	60% after deductible
Diagnostic Services			
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible	60% after deductible
Home Health Care	100%	80% after deductible	60% after deductible
	Benefit Limit: 90 visits/benefit period		
Hospice	100%	80% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment(3)	100%	80% after deductible	60% after deductible
Private Duty Nursing	100%	80% after deductible	60% after deductible
	Benefit Limit: 240 hours/benefit period		
Skilled Nursing Facility Care	100%	80% after deductible	60% after deductible
	Benefit Limit: 100 days/benefit period		
Transplant Services	100%	80% after deductible	60% after deductible
Precertification Requirements(4)	YES		
Prescription Drugs			
Prescription Drug Deductible Individual Family	None None		
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 with an Incentive Benefit Design.*	**Retail Drugs 34-Day Supply (Mandatory Generic)** $8 generic copayment $25 brand copayment - formulary $50 brand copayment – non-formulary **Maintenance Drugs through Mail Order 90-day Supply (Mandatory Generic)** $12 generic copayment $40 brand copayment – formulary $80 brand copayment – non-formulary		

Questions? Call 1-800-215-7865
Reference Code: P0020521

(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.
(5) The formulary is an extensive list of Food and 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. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.
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.

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.

(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.