HIGHMARK. PPO Blue

Summary of PPO Blue *Benefits (NG)*

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.

I.U. #1 - Bronze Plan

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $3,000 $6,000	 $5,000 $10,000
Plan Pays – payment based on the plan allowance	70% after deductible	60% after deductible
Out-of-Pocket Limit (Includes prescription drug expenses, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 $3,600 $7,200	 $10,000 $20,000
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	 $7,150 $14,300	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	70% after deductible	60% after deductible
Primary Care Provider Office Visits	70% after deductible	60% after deductible
Specialist Office & Virtual Visits	70% after deductible	60% after deductible
Urgent Care Center Visits	70% after deductible	60% after deductible
Telemedicine Services (8)	70% after deductible	Not Covered
Preventive Care(3)		
Routine Adult		
Physical exams	100% (deductible does not apply)	60% after deductible
Adult immunizations	100% (deductible does not apply)	60% after deductible
Colorectal cancer screening	100% (deductible does not apply)	60% after deductible
Routine gynecological exams, including a Pap Test	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)	60% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	60% after deductible
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Emergency Services		
Emergency Room Services	70% after deductible (waived if admitted)	
Ambulance	70% after network deductible	
Ambulance – Non-Emergency	70% after deductible	60% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	70% after deductible	60% after deductible
Hospital Outpatient	70% after deductible	60% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	70% after deductible	60% after deductible
Medical Care (including inpatient visits and consultations)**/Surgical Expenses**	70% after deductible	60% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	70% after deductible	60% after deductible
	Limit: 20 visits/benefit period	
Respiratory Therapy	70% after deductible	60% after deductible
Speech & Occupational Therapy	70% after deductible	60% after deductible
	Limit: 20 visits per therapy/benefit period	
Spinal Manipulations	70% after deductible	60% after deductible
	Limit: 20 visits/benefit period	

Benefit	Network	Out-of-Network
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	70% after deductible	60% after deductible
Mental Health/Substance Abuse		
Inpatient	70% after deductible	60% after deductible
Inpatient Detoxification/Rehabilitation	70% after deductible	60% after deductible
Outpatient	70% after deductible	60% after deductible
Other Services		
Allergy Extracts and Injections	70% after deductible	60% after deductible
Autism Spectrum Disorder including Applied Behavior Analysis(4)	70% after deductible	60% after deductible
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.)	70% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	70% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	70% after deductible	60% after deductible
Home Health Care	70% after deductible	60% after deductible
	Limit: 90 visits/benefit period	
Hospice	70% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment(5)	70% after deductible	60% after deductible
Private Duty Nursing	70% after deductible	60% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	70% after deductible	60% after deductible
	Limit: 100 days/benefit period	
Transplant Services	70% after deductible	60% after deductible
Precertification Requirements(6)	Yes	
Prescription Drugs		
Prescription Drug Deductible		
Individual	Integrated with medical deductible	
Family	Integrated with medical deductible	
Prescription Drug Program(7) *Defined by the National 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	

(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.
(3) 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.
(4) 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.
(5) 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.
(6) 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.
(7) At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your 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.
(8) 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 benefit.

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 as required, 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.

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