HIGHMARK. PPOBlue
A Preferred-Provider Program

California Area School District *Plan D5 (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.

10/1/2016

Benefit	Network	Out-of-Network
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual Family	 None None	 $250 $500
Plan Pays – payment based on the plan allowance	100%	80% after deductible
Out-of-Pocket Limit (Once met, plan pays 100%for the rest of the benefit period) Individual Family	 None None	 $2,000 $4,000
Total Maximum Out-of-Pocket (includes deductible, coinsurance, copays, prescription drug cost share 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	 $6,850 $13,700	 Not Applicable Not Applicable
Autism Spectrum Disorders Maximum (per person) **(2)**	$40,000/benefit period	
Office/Clinic/Urgent Visits		
Retail Clinic Visits	**100% after $25 copayment**	80% after deductible
Primary Care Provider Office Visits	**100% after $25 copayment**	80% after deductible
Specialist Office Visits	**100% after $25 copayment**	80% after deductible
Urgent Care Center Visits	**100% after $25 copayment**	80% after deductible
Preventive Care (3)		
Routine Adult Physical exams	 **100%**	 Not Covered
Adult Immunizations	**100%**	80% after deductible
Colorectal cancer screening	**100%**	80% after deductible
Routine gynecological exams, including a Pap Test	**100%**	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	**100%**	80% after deductible
Diagnostic services and procedures	**100%**	80% after deductible
Routine Pediatric Physical exams	 **100%**	 Not Covered
Pediatric immunizations	**100%**	80% (deductible does not apply)
Diagnostic services and procedures	**100%**	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient **Hospital Outpatient** **Maternity (non-preventive facility & professional services)** **Medical/Surgical and procedures** (except office visits)	100% after deductible	80% after deductible
Emergency Services		
Emergency Room Services	100% after $100 copayment (waived if admitted)	
Ambulance	100%	
Therapy and Rehabilitation Services		
Physical Medicine	100% after $10 copayment	80% after deductible
	Limit: 20 visits/benefit period	
Respiratory Therapy	100%	
Speech & Occupational Therapy	100% after $10 copayment	80% after deductible
	Limit: 20 visits per therapy /benefit period	
Spinal Manipulations	100% after $20 copayment	80% after deductible
	Limit: 20 visits/benefit period	

Benefit	Network	Out-of-Network
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible
Mental Health/Substance Abuse		
Inpatient	100%	80% after deductible
Inpatient Detoxification/Rehabilitation	100%	80% after deductible
Outpatient	100%	80% after deductible
Other Services		
Allergy Extracts and Injections	100%	80% after deductible
Applied Behavior Analysis for Autism Spectrum Disorders (2)	100%	80% after deductible
Assisted Fertilization Procedures	Not covered	
Dental Services Related to Accidental Injury	100%	80% after deductible
Diagnostic Services **Advances Imaging** (MRI, CAT, PET scan, etc.)	100%	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible
Home Health Care	100%	80% after deductible
Hospice	100%	80% after deductible
Infertility Counseling, Testing and Treatment (4)	100%	80% after deductible
Private Duty Nursing	100%	
Skilled Nursing Facility Care	100%	80% after deductible Limit: 100 days/benefit period
Transplant Services	100%	80% after deductible
Precertification Requirements (5)	100%	80% after deductible
Transplant Services	100%	80% after deductible
Precertification Requirements (5)	Yes	
Prescription Drug Deductible Individual Family	 None None	
Prescription Drug Program: **Defines 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** $10 generic copayment $20 brand copayment **Mandatory Generic (6)** **34-day supply** **Maintenance Drugs through Mail Order** **$10 generic copayment** **$20 brand copayment** **Mandatory Generic (6)** **90-day Supply**	

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) 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 ASD benefit period dollar maximum applies, only non-essential health benefits will accumulate.
(3) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
(4) 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.
(5) 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.
(6) You are responsible for the payment differential when a generic drug is authorized by your doctor and you elect to 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.
(7) Effective with plan years beginning on or after January 1, 2016 the Network Total Maximum Out-of-Pocket as mandated by the federal government must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. The Total Maximum Out-of-Pocket cannot be more than $6,850 for individual and $13,700 for two or more persons.

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.