HIGHMARK. PPO Blue

Intermediate Unit 1 Health Insurance Consortium Plan G (G)

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	Network	Out-of-Network
General Provisions		
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
Autism Spectrum Disorders (ASD) Maximum (per person)(2)	$40,000/benefit period	
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $10 copayment	80% after deductible
Primary Care Provider Office Visits	100% after $10 copayment	80% after deductible
Specialist Office Visits	100% after $10 copayment	80% after deductible
Urgent Care Center Visits	100% after $10 copayment	80% after deductible
Preventive Care(3)		
Routine Adult		
Physical exams	100% after $10 copayment	Not Covered
Adult immunizations	100%	80% after deductible
Colorectal cancer screening	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100% after $10 copayment	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% after $10 copayment	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** (except office visits)	100%	80% after deductible
Emergency Services		
Emergency Room Services	100% after $25 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 $10 copayment	80% after deductible Limit: 20 visits/benefit period
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	100%	80% after deductible
Outpatient	100%	80% after deductible
Other Services		
Allergy Extracts and Injections **Applied Behavior Analysis for Autism Spectrum Disorders**(2)	100%	80% after deductible

Benefit	Network	Out-of-Network
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	100%	80% after deductible
Diagnostic Services *Advanced 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 **Home Health Care** **Hospice** **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)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual Family	 None None	
Prescription Drug Program (6) *Defined by the Premier 2012 Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Comprehensive Formulary*	**Retail Drugs** $5 generic copayment $15 brand copayment – formulary $30 brand non-formulary Mandatory Generic 34 day supply **Maintenance Drugs through Mail Order (90-day Supply)** $10 generic copayment $30 brand copayment – formulary $60 brand copayment non-formulary 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 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 not, you are responsible for contacting MM&P. 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) 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. 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.