HIGHMARK. | PPO Blue

PPO Blue Sharing $150 w/Rx

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)	Contract Year	
Deductible (per benefit period) Individual Family	 $150 $300	 $600 $1,200
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 $4,000 $8,000
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	 $3,500 $7,000	 $4,000 $8,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $15 copay	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $20 copay	80% after deductible
Specialist Office & Virtual Visits	100% after $30 copay	80% after deductible
Virtual Visit Originating Site Fee	100%	80% after deductible
Urgent Care Center Visits	100% after $30 copay	100% after $30 copay
Telemedicine Services(3)	100% after $10 copay	Not Covered
Preventive Care(4)		
Routine Adult Physical exams	 100%	 80% after deductible
Adult immunizations	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100%	80% after deductible
Mammograms, annual routine	100%	80% after deductible
Mammograms, medically necessary	100%	80% after deductible
Women's Health (screenings, supplies and counseling)	100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
Routine Pediatric Physical exams	 100%	 80% after deductible
Pediatric immunizations	100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
Emergency Services		
Emergency Room Services	100% after $100 copay (waived if admitted)	
Ambulance – Emergency	100% after network deductible	
Ambulance – Non-Emergency	100%	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100% after $100 copay (per admission)	80% after deductible
Hospital Outpatient	100% after $30 copay (per admission)	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after $100 copay (per admission)	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $15 copay Limit: 60 visits/benefit period	80% after deductible
Respiratory Therapy	100%	80% after deductible
Speech & Occupational Therapy	100% after $15 copay	80% after deductible

Benefit	Network	Out-of-Network
	Limit: 60 visits per therapy/benefit period	
Spinal Manipulations	100% after $15 copay	80% after deductible
	Limit: 25 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Inpatient Mental Health Services	100% after $100 copay (per admission)	100% after $100 copay (per admission)
Inpatient Detoxification / Rehabilitation	100% after $100 copay (per admission)	100% after $100 copay (per admission)
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $15 copay	100% after $15 copay
Outpatient Substance Abuse Services	100% after $15 copay	100% after $15 copay
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Autism Spectrum Disorder including Applied Behavior Analysis(5)	100% after deductible	80% after deductible
Infertility Treatment (diagnosis and treatment of the underlying medical condition only)	Cost sharing is based on the type of service and where it is performed	Cost sharing is based on the type of service and where it is performed
Vasectomy	Cost sharing is based on the type of service and where it is performed	Cost sharing is based on the type of service and where it is performed
Tubal ligation	100% deductible waived	80% after deductible
Diabetic Supplies	100% deductible waived	80% after deductible
Hearing Aids (Limited $1,000 per lifetime)	100% deductible waived	80% after deductible
Diagnostic Services *Advanced Imaging* (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	Limit: 120 visits/benefit period	
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment(6)	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after $100 copay	80% after deductible
	Limit: 90 days/benefit period	
Transplant Services	$100 copay; deductible waived	80% after deductible
Precertification Requirements(7)	Yes	
Prescription Drugs		
Prescription Drug Deductible (must be satisfied before any drug benefits are paid. For Retail Drugs only.) Individual Family	$50.00 $150.00	

Benefit	Network	Out-of-Network
(Deductible waived for low cost generic, generic and mail order generic) Prescription Drug Program(8) Hard Mandatory Generic: the member pays the applicable copay. If the physician requires brand-name, member would pay brand-name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.	**Retail Drugs (31/60/90-day Supply)** $3/$6/$9 low cost generic $15/$30/$45 generic copay **Formulary Brand (31/60/90-day Supply)** 10% (min $25; max $100)/ 10% ($40 min, $200 max)/ 10% ($60 min, $300 max) **Non-formulary Brand (31/60/90-day Supply)** 10% (min $45; max $100) / 10% ($80 min, $300 max) / 10% (min $120, $400 max) 10% (min $25; max $150) preferred specialty 10% (min $45; max $150) non- preferred specialty **Maintenance Drugs through Mail Order (90-day Supply)** $6 low cost generic $30 generic copay $50 formulary brand copay $90 non-formulary brand copay 10% (min $25; max $150) preferred specialty 10% (min $45; max $150) non- preferred specialty	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(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. Effective with plan years beginning on or after January 1, 2016, the TMOOP cannot exceed $6,850 for individual and $13,700 for two or more persons.

(3) 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.

(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).

(5) 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.

(6) 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.

(7) 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.

(8) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed.