HIGHMARK. PPO Blue

# Juniata College

## PPO Blue Sharing

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.

104071-79, 104071-80

| Benefit | Network | Out-of-Network |
|---|---|---|
| **General Provisions** | | |
| Benefit Period(1) | Contract Year | |
| Deductible (per benefit period)<br>Individual<br>Family | <br>$250<br>$500 | <br>$700<br>$1,400 |
| 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)<br>Individual<br>Family | <br>None<br>None | <br>$4,000<br>$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.<br>Individual<br>Family | <br>$3,500<br>$7,000 | <br>N/A<br>N/A |
| **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 |
| Maternity-Professional (including dependent daughter) | 100% after deductible | 80% after deductible |
| Telemedicine Services(3) | 100% after $10 copay | Not Covered |
| **Preventive Care(4)** | | |
| Routine Adult<br>Physical exams | <br>100% | <br>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 & 3D Mammograms | 100% | 80% after deductible |
| Women's Health- Breast Feeding supplies All screenings, and counseling | 100% | 80% after deductible |
| Diagnostic services and procedures | 100% | 80% after deductible |
| Routine Pediatric<br>Physical exams | <br>100% | <br>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 (Non-Emergency, Ground, Air and Water) | 100% (deductible does not apply) | |
| Non-Emergency & Non-Urgent use of Urgent Care provider | 100% after a $30 copay | 100% after a $30 copay |
| **Hospital and Medical/Surgical Expenses (including maternity)** | | |
| Hospital Inpatient | 100% after $100 copay (per admission) | 80% after deductible |
| Hospital Outpatient- Excludes emergency room services | 100% after $30 copay | 80% after deductible |
| Maternity (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<br>Limit: 60 visits/benefit period | 80% after deductible |
| | | |
| Speech, Occupational & Respiratory Therapy | 100% after $15 copay<br>Limit: 60 visits per therapy/benefit period | 80% after deductible |
| Spinal Manipulations | 100% after $15 copay<br>Limit: 25 visits/benefit period | 80% after deductible |
| 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 |

| Benefit | Network | Out-of-Network |
|---|---|---|
| Outpatient Substance Abuse Services | 100% after $15 copay | 100% after $15 copay |
| **Other Services** | | |
| Allergy Extracts and Injections | 100% deductible waived | 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) | 100% after deductible | 80% after deductible |
| Contraceptives | 100% after deductible | 80% after deductible |
| Vasectomy | 100% after deductible | 80% after deductible |
| 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<br>*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% deductible waived | 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 |
| Skilled Nursing Facility Care-Applies to Facility | 100% after $100 copay | 80% after deductible |
| | Limit: 90 days/benefit period | |
| Transplant Services | 100% after $100 copay | 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.)<br>Individual<br>Family | $50.00<br>$150.00 | |
| (Deductible waived for low cost generic, generic and mail order generic)<br><br>Prescription Drug Program(8)<br><br>Soft 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<br><br>Prescriptions filled at a non-network pharmacy are not covered.<br><br>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design. | **Retail Drugs (31/60/90-day Supply)**<br>$3/$6/$9 low cost generic<br>$15/$30/$45 generic copay<br>**Formulary Brand (31/60/90-day Supply)**<br>10% (min $25; max $100)/ 10% ($40 min, $200 max)/ 10% ($60 min, $300 max)<br>**Non-formulary Brand (31/60/90-day Supply)**<br>10% (min $45; max $100) / 10% ($80 min, $300 max) / 10% (min $120, $400 max)<br>10% (min $25; max $150) preferred specialty<br>10% (min $45; max $150) non- preferred specialty<br><br>**Maintenance Drugs through Mail Order (90-day Supply)**<br>$6 low cost generic<br>$30 generic copay<br>$50 formulary brand copay<br>$90 non-formulary brand copay<br>10% (min $25; max $150) preferred specialty<br>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.