HIGHMARK. | PPO Blue

PPO Blue Benefit Summary – Effective 1-1-2017

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.

Groups: 25079-00, 25079-06

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period ①	Calendar Year	
Deductible (per benefit period) Individual Family	 $400 $800	 $800 $1,600
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period) Individual Family	 Not Applicable	 $3,200 $6,400
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	 None None
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits ③	100% after $25 copayment	80% after deductible
Primary Care Provider Office Visits & Virtual Visits ③	100% after $20 copayment	80% after deductible
Specialist Office & Virtual Visits ④	100% after $45 copayment	80% after deductible
Virtual Visit Originating Site Fee ④	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $50 copayment	80% after deductible
Preventive Care with Enhancements ⑤		
Routine Adult Physical exams	 100% no deductible	 80% after deductible
Adult immunizations	100% no deductible	80% after deductible
Colorectal cancer screening	100% no deductible	80% after deductible
Routine gynecological exams, including a Pap Test	100% no deductible	80% no deductible
Mammograms, annual routine and medically necessary	100% no deductible	80% after deductible
Diagnostic services and procedures	100% no deductible	80% after deductible
Routine PSA Screening	100% no deductible	80% after deductible
Routine Pediatric Physical exams	 100% no deductible	 80% after deductible
Pediatric immunizations	100% no deductible	80% no deductible
Diagnostic services and procedures	100% no deductible	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient/Outpatient	100% after deductible 365 days	80% after deductible
Maternity (non-preventive facility & professional services)	100% after deductible	80% after deductible
Medical Care (except office visits) Includes Inpatient Visits and Consultations	100% after deductible	80% after deductible
Surgical Expenses (except office visits) Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures. Excludes Neonatal Circumcision	100% after deductible	80% after deductible
Emergency Services		
Emergency Room Services	100% after $200 copayment (waived if admitted)	
Ambulance (emergency)	100% no deductible	
Ambulance (non-emergency)	100% after deductible	80% after deductible
Mental Health/Substance Abuse		
Inpatient Mental Health	100% after deductible	80% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	80% after deductible
Outpatient Mental Health includes Virtual Behavioral Health Visits	100% after $45 copayment	80% after deductible
Outpatient Substance Abuse includes Virtual Behavioral Health Visits	100% after $45 copayment	80% after deductible

Therapy and Rehabilitation Services		
Physical Medicine Outpatient	100% after $45 copayment unlimited	80% after deductible
Respiratory Therapy	100% after deductible	80% after deductible
Spinal Manipulations	100% after $45 copayment 30 visits/benefit period	80% after deductible
Speech & Occupational Therapy Outpatient	100% after $45 copayment 30 visits per therapy/benefit period	80% after deductible
Other Therapy Services - Cardiac Rehabilitation, Chemotherapy, Radiation Therapy, Dialysis and Infusion Therapy	100% after deductible	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Applied Behavior Analysis for ASD ⑥	100% after deductible	80% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diabetes Treatment	100% after deductible	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
Elective Abortion	Not Covered (except in cases of rape, incest, or to avert death of the mother)	
Home Health Care (Excludes Respite Care)	100% after deductible 60 visits/benefit period	80% after deductible
Hospice (Includes Respite Care)	100% after deductible 180 days/benefit period	80% after deductible
Infertility Counseling, Testing and Treatment ⑦	100% after deductible	80% after deductible
Oral Surgery	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible 240 hours/benefit period	80% after deductible
Skilled Nursing Facility Care	100% after deductible 100 days/benefit period	80% after deductible
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements ⑧	Yes	

①Your group's benefit period is based on a Calendar Year.

②The 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, 2017, the TMOOP cannot exceed $7,150 for individual and $14,300 for two or more persons.

③Virtual, Retail & Behavior Virtual Visits – the purpose of this benefit is to allow a member to have a virtual visit through the use of secure telecommunications technology. The secure telecommunication technology must provide both audio and video streams. Virtual Visits can be conducted for initial, follow-up, or maintenance care. The member's responsibility is the copayment that would normally apply for an in-person primary care, retail or behavior visit.

④Virtual Specialist Office Visit – The purpose of this benefit is to allow a member to have a virtual follow up visit with a specialist that may be located a significant distance away. The member's responsibility is the copayment that would normally apply for an in-person specialist visit and a fee from the "originating site". The PCP's office or clinic that provided access to the video conferencing equipment may also charge a fee. The originating fee will be applied to the deductible and/or coinsurance as determined by the member's specific benefit design.

⑤Services are limited to those listed on the Highmark Preventive Schedule with Enhancements and Women's Health Preventive Schedule. Gender, age and frequency limits may apply.

⑥Coverage 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.

⑦Treatment 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.

⑧Highmark 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.

Customized