HIGHMARK. | PPO Blue

Summary of PPO Blue Premium $20 Rx B *Benefits*

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	 None None	 $500 $1,000
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	 None None	 $3,000 $6,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $20 copayment	80% after deductible
Primary Care Provider Office Visits	100% after $20 copayment	80% after deductible
Specialist Office & Virtual Visits	100% after $20 copayment	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $35 copayment	80% after deductible
Telemedicine Service(2)	100% after $10 copayment	
Preventive Care(3)		
Routine Adult		
Physical exams	100% (deductible does not apply)	80% after deductible
Adult immunizations	100% (deductible does not apply)	80% after deductible
Colorectal cancer screening	100% (deductible does not apply)	80% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% after deductible	80% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	80% after deductible
Pediatric immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	
Medical Care (including inpatient visits and consultations)**/Surgical Expenses**	100% after deductible	
Emergency Services		
Emergency Room Services	100% after $50 copayment (waived if admitted)	
Ambulance	100% after deductible	100% after deductible
Ambulance – Non-Emergency	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $20 copayment Limit: 20 visits/benefit period	80% after deductible
Respiratory Therapy	100% after deductible	80% after deductible
Speech & Occupational Therapy	100% after $20 copayment Limit: 20 visits per therapy/benefit period	80% after deductible
Spinal Manipulations	100% after $20 copayment Limit: 20 visits/benefit period	80% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health/Substance Abuse		
Inpatient	100% after deductible	80% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	
Outpatient	100% after deductible	
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	Not Covered	Not Covered
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 Limit: 90 visits/benefit period	80% after deductible
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment(4)	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible Limit: 240 hours/benefit period	80% after deductible

Benefit	Network	Out-of-Network
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	Limit: 100 days/benefit period	
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements(5)	YES	
Prescription Drugs		
Prescription Drug Deductible		
Individual	None	
Family	None	
Prescription Drug Program(6) Hard Mandatory Generic *Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary with an Closed Benefit Design.*	**Retail Drugs (31/60/90-day Supply)** $8/$16/$24 generic copayment $40/$80/$120 formulary brand copayment **Maintenance Drugs through Mail Order (90-day Supply)** $16 generic copayment $80 formulary brand copayment	

(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) Services must be performed by a Highmark approved telemedicine provider.
(3) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). 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 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) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. To obtain a prescription medication that is not included on this formulary, your provider must complete the 'Prescription Drug Medication Request Form' and return it to the Pharmacy Affairs Department for clinical review.Under the hard mandatory generic provision, you are responsible for the payment differential when a generic drug is available and you or your provider specifies a brand name drug. Your payment is the price difference between the brand name drug and the generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.