HIGHMARK. | PPO Blue

Plan C- 012117-02

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	In Network	Out of Network
General Provisions		
Effective Date	1/1/2022	
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $1,000 $3,000	 $3,000 $9,000
Plan Pays – payment based on the plan allowance	70% after deductible	50% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 $6,000 $18,000	 $18,000 $54,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	70% after deductible	50% after deductible
Primary Care Provider Office Visits	70% after deductible	50% after deductible
Virtual Visits (with your PCP)	100% after $25 copay	50% after deductible
Specialist Office Visits	70% after deductible	50% after deductible
Virtual Visits (with your Specialist	100% after $25 copay	50% after deductible
Urgent Care Center Visits	100% after $25 copay	50% after deductible
Telemedicine Services – Teladoc (3)	100% after $10 copay	not covered
Preventive Care (4)		
Routine Adult Physical Exams	100% (deductible does not apply)	100% (deductible does not apply)
Adult Immunizations	100% (deductible does not apply)	100% (deductible does not apply)
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	100% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	100% (deductible does not apply)
Mammograms, Medically Necessary	70% after deductible	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	100% (deductible does not apply)
Routine Pediatric Physical Exams	100% (deductible does not apply)	100% (deductible does not apply)
Pediatric Immunizations	100% (deductible does not apply)	100% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	100% (deductible does not apply)
Emergency Services		
Emergency Room Services	70% after deductible	70% after deductible in-network deductible applies
Ambulance - Emergency and Non-Emergency	70% after deductible	70% after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	70% after deductible	50% after deductible
Hospital Outpatient	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services)	100% after deductible	50% after deductible
Maternity for Dependent Daughters	100% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	70% after deductible	50% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	70% after deductible	50% after deductible
Respiratory Therapy	70% after deductible	50% after deductible
Speech Therapy	70% after deductible	50% after deductible
Occupational Therapy	70% after deductible	50% after deductible
Spinal Manipulations	70% after deductible	50% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	70% after deductible	50% after deductible

Benefit	In Network	Out of Network
Mental Health / Substance Abuse		
Inpatient Mental Health Services	70% after deductible	50% after deductible
Inpatient Detoxification / Rehabilitation	70% after deductible	50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $25 copay	50% after deductible
Outpatient Substance Abuse Services	100% after $25 copay	50% after deductible
Other Services		
Allergy Extracts and Injections	70% after deductible	50% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (5)	70% after deductible	50% after deductible
Assisted Fertilization Procedures	70% after deductible	50% after deductible
	Lifetime maximum benefit: $20,000 (combined procedures and prescriptions) Limitations apply: Limited to 3 IVF cycles when medically necessary up to age 40.	
Dental Services Related to Accidental Injury	70% after deductible	50% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	70% after deductible	50% after deductible
Standard Imaging	70% after deductible	50% after deductible
Diagnostic Medical	70% after deductible	50% after deductible
Pathology/Laboratory	70% after deductible	50% after deductible
Allergy Testing	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	70% after deductible	50% after deductible
Home Health Care	70% after deductible	50% after deductible
Hospice	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (6)	70% after deductible	50% after deductible
Private Duty Nursing	70% after deductible	50% after deductible
Skilled Nursing Facility Care	70% after deductible	50% after deductible
Transplant Services	70% after deductible	50% after deductible
Precertification Requirements (7)	No	No

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 Calendar Year which runs from January 1 to December 31.

(2) Not Applicable

(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 benefit.

(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. After initial analysis, 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.

(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.