County of Lehigh – Actives
PPOBlue Benefit Summary

PAYMENT LEVEL	IN-NETWORK DEDUCTIBLE	OFFICE VISITS	EMERGENCY ROOM SERVICES
90%/70%	**$250/$500**	**$15/$25 COPAY**	**$75 COPAY**

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Benefit Period	Contract Year *Twelve consecutive months beginning on the contract date*	
Deductible ⑤ *Per Benefit Period*	$250 Individual $500 Family Aggregate	$1,000 Individual $2,000 Family Aggregate
Payment Level *Based on Provider's Reasonable Charge (PRC)*	90% PRC after deductible until out-of-pocket limit is met; then 100% PRC	70% PRC after deductible until out-of-pocket limit is met; then 100% PRC
Out-of-Pocket Limit *Includes Coinsurance, certain exclusions may apply*	$3,000 Individual $6,000 Family Aggregate	$3,000 Individual $6,000 Family Aggregate
Autism Spectrum Disorders (ASD) Maximum *(per person)* ⑦	$36,000/benefit period	
Lifetime Maximum	Unlimited	
Ambulance - Emergency	100% PRC no deductible	
Ambulance – Non-Emergency	90% PRC after deductible	70% PRC after deductible
Applied Behavior Analysis for ASD ⑦	90% PRC after deductible	70% PRC after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to an Accidental Injury	90% PRC after deductible	70% PRC after deductible
Diabetes Treatment	90% PRC after deductible	70% PRC after deductible
Diagnostic Services *Advanced Imaging (MRI, CAT, PET scan, etc.)*	90% PRC after deductible	70% PRC after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% PRC after deductible	70% PRC after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% PRC after deductible	70% PRC after deductible
Emergency Room Services	100% PRC after $75 Copay – waived if admitted	
Urgent Care	100% PRC after $75 Copay – waived if admitted	70% PRC after deductible
Enteral Formulae	90% PRC no deductible	70% PRC no deductible
Hearing Care Services ④	Not Covered	Not Covered
Home Health Care *Excludes Respite Care*	90% PRC after deductible 90 visits/benefit period	70% PRC after deductible
Hospice *Includes Respite Care*	90% PRC after deductible	70% PRC after deductible
Hospital Expenses *Inpatient*	90% PRC after deductible	70% PRC after deductible
Hospital Expenses *Outpatient*	90% PRC after deductible	70% PRC after deductible
Infertility Counseling, Testing and Treatment *Treatment includes coverage for the correction of a physical or medical problem associated with infertility.*	90% PRC after deductible	70% PRC after deductible
Maternity *Includes Dependent Daughters*	90% PRC after deductible	70% PRC after deductible
Medical Care *Includes Inpatient Visits and Consultations*	90% PRC after deductible	70% PRC after deductible

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Mental Health *Inpatient ②*	90% PRC after deductible	70% PRC after deductible
Mental Health *Outpatient ②*	100% PRC after $25 Copay	70% PRC after deductible
Office Visits *Primary Care Physician* *Specialty Care Physician*	 100% PRC after $15 Copay 100% PRC after $25 Copay	 70% PRC after deductible 70% PRC after deductible
Oral Surgery	90% PRC after deductible	70% PRC after deductible
Physical Medicine *Outpatient*	100% PRC after $25 Copay Unlimited visits/benefit period	70% PRC after deductible
Preventive Care ③ *Routine Adult* *Physical Exams* *Adult Immunizations* *Colorectal Cancer Screening* *Diagnostic Services and Procedures* *Mammograms, annual routine and medically necessary* *Routine Gynecological Exam* *Pap Test*	 100% PRC no deductible 100% PRC no deductible 100% PRC no deductible 100% PRC no deductible 100% PRC no deductible 100% PRC no deductible 100% PRC no deductible	 70% PRC after deductible 70% PRC after deductible 70% PRC after deductible 70% PRC after deductible 70% PRC after deductible 70% PRC no deductible 70% PRC no deductible
Routine Pediatric *Physical Exams* *Pediatric Immunizations* *Diagnostic Services and Procedures*	 100% PRC no deductible 100% PRC no deductible 100% PRC no deductible	 70% PRC after deductible 70% PRC no deductible 70% PRC after deductible
Private Duty Nursing	90% PRC after deductible 240 hours/benefit period	70% PRC after deductible
Skilled Nursing Facility Care	90% PRC after deductible 100 days/benefit period	70% PRC after deductible
Speech & Occupation Therapy *Outpatient*	100% PRC after $25 Copay 12 visits/benefit period/type of therapy	70% PRC after deductible
Spinal Manipulations	100% PRC after $25 Copay Unlimited visits/benefit period	70% PRC after deductible
Substance Abuse *Detoxification*	90% PRC after deductible	70% PRC after deductible
Substance Abuse *Inpatient Rehabilitation*	90% PRC after deductible	70% PRC after deductible
Substance Abuse *Outpatient*	100% PRC after $25 Copay	70% PRC after deductible
Surgical Expenses *Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, and Neonatal Circumcision*	90% PRC after deductible	70% PRC after deductible
Therapy and Rehabilitation Services *Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy*	90% PRC after deductible	70% PRC after deductible
Respiratory Therapy	100% PRC after $25 Copay 30 visits/benefit period	70% PRC after deductible
Transplant Services	90% PRC after deductible	70% PRC after deductible
Precertification Requirements for Inpatient Admissions *No Penalty for Non-compliance. If Highmark Blue Shield is not contacted prior to a non-emergency out-of-network inpatient admission and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the member will be responsible for any costs not covered.*	Performed by Network Provider	Performed by Member
Condition Management	Case Management, Blues on Call, and Disease State Management	

① 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.
② State mandated minimum benefits may apply to a diagnosis of serious mental illness. (If the above grid does not show a limit, your mental health benefit days and visits are unlimited.)
③ Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
④ This applies to Routine hearing services only.
⑤ Please be advised that your provider may ask for payment toward your deductible at time of service.