HIGHMARK. PPO Blue

County of Lehigh – Actives 025377-25, 26, 27, 28, 29, 30, 31, 32

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	 $250 $500	 $1,000 $2,000
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period) Individual Family	 $3,000 $6,000	 $3,000 $6,000
Autism Spectrum Disorders (ASD) Maximum (per person)(2)	$36,000/benefit period	
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $25 copayment	70% after deductible
Primary Care Provider Office Visits	100% after $15 copayment	70% after deductible
Specialist Office Visits	100% after $25 copayment	70% after deductible
Virtual Visit Originating Site Fee	90% after deductible	70% after deductible
Urgent Care Center Visits	100% after $75 copayment	70% after deductible
Preventive Care(3)		
Routine Adult Physical exams	 100% (deductible does not apply)	 70% after deductible
Adult immunizations	100% (deductible does not apply)	70% after deductible
Colorectal cancer screening	100% (deductible does not apply)	70% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	70% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	70% after deductible
Routine Pediatric Physical exams	 100% (deductible does not apply)	 70% after deductible
Pediatric immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	70% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient **Hospital Outpatient** **Maternity** (non-preventive facility & professional services) **Medical/Surgical** (except office visits)	90% after deductible	70% after deductible
Emergency Services		
Emergency Room Services	100% after $75 copayment (waived if admitted)	
Ambulance - Emergency	100% no deductible	
Ambulance – Non-Emergency	90% after deductible	70% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $25 copayment Unlimited visits/benefit period	70% after deductible
Respiratory Therapy	100% after $25 copayment 30 visits/benefit period	70% after deductible
Spinal Manipulations	100% after $25 copayment Unlimited visits/benefit period	70% after deductible
Speech & Occupational Therapy	100% after $25 copayment Limit: 12 visits per therapy/benefit period	70% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	90% after deductible	70% after deductible
Outpatient	100% after $25 copayments	70% after deductible
Other Services		
Allergy Extracts and Injections **Applied Behavior Analysis for Autism Spectrum Disorders** (2)	90% after deductible	70% after deductible
Assisted Fertilization Procedures	Not Covered	

Benefit	Network	Out-of-Network
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	70% after deductible
Home Health Care	90% after deductible	70% after deductible
	Limit: 90 visits/benefit period	
Hospice	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment(4)	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	Limit: 100 days/benefit period	
Transplant Services ***(Include Transportation and Lodging Services)***	90% after deductible	70% after deductible
Precertification Requirements(5)	Yes	
Prescription Drugs		
Prescription Drug Deductible		
Individual	None	
Family	None	
Prescription Drug Program(6) Mandatory Generic *Defined by the Premier 2012 Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary.*	**Retail Drugs (31-/60-/90-day Supply)** $4/$8/$8 generic copayment $35/$70/$70 formulary brand copayment $50/$100/$100 non-formulary brand copayment **Maintenance Drugs through Mail Order (90-day Supply)** $8 generic copayment $70 formulary brand copayment $100 non-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) 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.

(3) Services are limited to those listed on the Highmark Preventive Schedule and Women's Health Preventive Schedule. 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 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.

(6) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above.You are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

Please be advised that your provider may ask for payment toward your deductible and or coinsurance at time of service.