HIGHMARK. | PPO Blue

LCIC Montoursville ASD PPO Blue Plan C 10213015, 10213016, 10213017
Effective: 7-1-2020

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		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual Family	 none none	 $200 $600
Plan Pays – payment based on the plan allowance	100%	80% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 none none	 $2,000 $6,000
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	 $8,150 $16,300	 not applicable not applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $10 copay	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $10 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after $20 copay	80% after deductible
Virtual Visit Originating Site Fee	100%	80% after deductible
Urgent Care Center Visits	100% after $20 copay	80% after deductible
Telemedicine Services (3)	100% after $5 copay	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100%	 80% after deductible
Adult Immunizations	100%	80% after deductible
Routine Gynecological Exams, including a Pap Test	100%	80% (deductible does not apply)
Mammograms, Annual Routine	100%	80% after deductible
Mammograms, Medically Necessary	100%	80% after deductible
Diagnostic Services and Procedures	100%	80% after deductible
Routine Pediatric Physical Exams	 100%	 80% after deductible
Pediatric Immunizations	100%	80% (deductible does not apply)
Diagnostic Services and Procedures	100%	80% after deductible
Emergency Services		
Emergency Room Services	100% after $50 copay (waived if admitted)	
Ambulance (includes coverage for wheelchair van transports)	100%	100% (deductible does not apply) for emergencies; 80% after deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	100%	80% after deductible
Hospital Outpatient	100%	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100%	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100%	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $20 copay limit: 20 visits/benefit period	80% after deductible

Benefit	In Network	Out of Network
Respiratory Therapy	100%	80% after deductible
Speech Therapy	100% after $20 copay	80% after deductible
	limit: 12 visits/benefit period	
Occupational Therapy	100% after $20 copay	80% after deductible
	limit: 12 visits/benefit period	
Spinal Manipulations	100% after $20 copay	80% after deductible
	limit: 12 visits/benefit period	
Cardiac Rehabilitation Therapy	100%	80% after deductible
Infusion Therapy	100%	80% after deductible
Chemotherapy	100%	80% after deductible
Radiation Therapy	100%	80% after deductible
Dialysis	100%	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100%	80% after deductible
Inpatient Detoxification / Rehabilitation	100%	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100%	80% after deductible
Outpatient Substance Abuse Services	100%	80% after deductible
Other Services		
Allergy Extracts and Injections	100%	80% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	100%	80% after deductible
	Limit: $40,000 annual maximum	
Assisted Fertilization	not covered	not covered
Dental Services Related to Accidental Injury	100%	80% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after $75 copay	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
Durable Medical Equipment and Supplies	100%	80% after deductible
Orthotics	100%	80% after deductible
Prosthetic Devices	100%	80% after deductible
Home Health Care	100% after $20 copay	80% after deductible
Hospice	100%	80% after deductible
	limit: 180 days/ lifetime maximum of 30 days can be used for continuous or inpatient care 10 days/ lifetime can be used for respite care	
Infertility Counseling, Testing and Treatment (6)	100%	80% after deductible
Private Duty Nursing	not covered	not covered
Skilled Nursing Facility Care	100%	80% after deductible
	limit: 60 days/benefit period	
Transplant Services	100%	80% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	

Benefit	In Network	Out of Network
Prescription Drug Program (8) 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 Incentive Benefit Design	**Retail Drugs (30-day Supply)** $3 low cost generic copay $3 formulary low cost generic copay $3 non-formulary low cost generic copay $10 formulary generic copay $10 non-formulary generic copay $20 formulary brand copay $35 non-formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $6 low cost generic copay $6 formulary low cost generic copay $6 non-formulary low cost generic copay $20 formulary generic copay $20 non-formulary generic copay $40 formulary brand copay $70 non-formulary brand copay	

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) The 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.
(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. 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. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(7) Be sure your provider is aware that Highmark Utilization Management must be contacted for authorization prior to a planned inpatient admission or within 48 hours of an emergency or unplanned inpatient admission. Also note that certain outpatient procedures require prior authorization. If authorization is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate you will be responsible for the payment of any costs not covered by your health plan.
(8) At a retail or mail-order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled. The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the hard mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs. With the Active Choice program, you must choose how you want to fill your maintenance prescription drugs. You may choose a retail pharmacy or your mail order program. If after two fills at a retail pharmacy you have not made your selection, you will need to pay full cost of the drug allowed by your plan for any future refills. You can change your selection at any time. Your plan requires that you use Alliance Rx Walgreens Prime specialty pharmacy for select specialty medications. To obtain medications for hemophilia, you must use a specific pharmacy, please contact member services for more details.