

Summary of 2017 PPOBlue Benefits

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 own 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.

Allegheny County Plan

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period ⁽¹⁾	Calendar Year	
Deductible (per benefit period)		
Individual	\$300	\$4,500
Family	\$600	\$13,500
Plan Pays – payment based on the plan allowance	100% after deductible	50% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	None	\$5,000
Family	None	\$15,000
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	\$7,150	Not Applicable
Family	\$14,300	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$25 copayment	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$25 copayment	50% after deductible
Specialist Office & Virtual Visits	100% after \$25 copayment	50% after deductible
Virtual Visit Originating Site Fee	100% after deductible	50% after deductible
Urgent Care Center Visits	100% after \$25 copayment	50% after deductible
Telemedicine Service ⁽³⁾	100% after \$25 copayment	Not Applicable
Preventive Care ⁽⁴⁾		
Routine Adult		
Physical exams	100% (deductible does not apply)	50% after deductible
Adult immunizations	100% (deductible does not apply)	Not Covered
Colorectal cancer screening	100% (deductible does not apply)	50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)	50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	Not Covered
Pediatric immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Emergency Services		
Emergency Room Services	100% after \$100 copayment (waived if admitted)	
Ambulance - Emergency	100% after network deductible	
Ambulance – Non-Emergency	100% after deductible	50% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/ Surgical Expenses	100% after deductible	50% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after \$25 copayment	50% after deductible
Respiratory Therapy	100% after deductible	50% after deductible

Benefit	Network	Out-of-Network
Speech & Occupational Therapy	100% after \$25 copayment	50% after deductible
Spinal Manipulations	100% after \$25 copayment Limit: 20 visits/benefit period	50% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	50% after deductible
Mental Health/Substance Abuse		
Inpatient	100% after deductible	50% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	50% after deductible
Outpatient - Includes Virtual Behavioral Health Visits	100% after \$25 copayment	50% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	50% after deductible
Autism Spectrum Disorder including Applied Behavior Analysis ⁽⁵⁾	100% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	100% after deductible	50% after deductible
Diagnostic Services		
<i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	100% after deductible	50% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	50% after deductible
Home Health Care	100% after deductible	50% after deductible Limit: 100 visits/benefit period
Hospice	100% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment ⁽⁶⁾	100% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	50% after deductible
Skilled Nursing Facility Care	100% after deductible	50% after deductible
Transplant Services	100% after deductible	50% after deductible
Precertification Requirements ⁽⁷⁾	Yes	
Prescription Drugs		
Prescription Drug Deductible	None	
Individual	None	
Family	None	
Prescription Drug Program ⁽⁸⁾	<i>(Prescriptions filled at a non-network pharmacy are not covered.)</i> Retail Drugs \$5 copayment generic \$20 copayment brand-formulary ⁽⁸⁾ \$50 copayment brand-non-formulary Mandatory Generic ⁽⁸⁾ 30-day supply Maintenance Drugs through Mail Order \$10 copayment generic \$40 copayment brand-formulary ⁽⁸⁾ \$100 copayment brand-non-formulary Mandatory Generic ⁽⁸⁾ 90-day Supply	
Mandatory Generic <i>Defined by the National Plus - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i> <i>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.</i>		

- 1) Your group's benefit period is based on a Calendar Year. The Calendar 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) 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. Effective with plan years beginning on or after January 1, 2016, the TMOOP cannot exceed \$7,150 for individual and \$14,300 for two or more persons.
- 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/Substance Abuse benefit.
- 4) 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.
- 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) 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.
- 8) The formulary is an extensive list of Food & 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. The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand drug. The member payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or insurance amounts which may apply.

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.