HIGHMARK. | PPO Blue

Pennsylvania Judiciary 028624-00, 01, 02, 03, 04, -05, -06
PPO Blue Benefit Summary - Effective 1-1-2023

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	 $250 $500
Plan Pays – payment based on the plan allowance	100%	Facility and Professional: 80% after deductible; until out-of-pocket limit is met; then 100%
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 $1,850 $3,600
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays 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	 $5,000 $10,000	 None None
Office/Clinic/Urgent Care Visits (One Copay per Provider per Date of Service)		
Retail Clinic Visits & Virtual Visits	100% after $10 copay	80% after deductible
Physician Office/Outpatient Visit and Consultation	100% after $10 copay	80% after deductible
Specialist Office & Virtual Visits	100% after $10 copay	80% after deductible
Virtual Visit Originating Site Fee	100%	80% after deductible
Urgent Care Center Visits	100% after $10 copay	80% after deductible
	The copayment, if any, does not apply to Urgent Care visits prescribed for the treatment of Mental Health or Substance Abuse	
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
Colorectal Cancer Screening	100%	80% after deductible
Routine Gynecological Exams, including a Pap Test	100%	80% (deductible does not apply)
Routine Foot Care – *Treatment of bunions, corns, calluses, and keratosis, cutting, trimming or removal of nails, hygienic and preventative self-care, treatment of fallen arches includes foot orthotic deices, flat or weak feet, chronic foot strain or symptomatic complaints of the feet*	100%	80% after deductible
Prostate Cancer Screening (Males Age 19 and over) One Examination per Benefit Period	100%	80% after deductible
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 (5)	100% after $35 copay (waived if admitted)	
Ambulance – Emergency (ground/water/air)	100%	100% of Charge
Ambulance – Non-Emergency (ground/water/air) (6)	100%	80% after deductible

Benefit	In Network	Out of Network
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)	100%	80% after deductible
Surgical Expenses (except office visits) Includes Assistant Surgery, Anesthesia, Sterilization, Reversal Procedures and Neonatal Circumcision	100%	80% after deductible
Therapy and Rehabilitation Services (One Copay per Provider per Date of Service)		
Physical Medicine	100% after $10 copay	80% after deductible
	Limit: 60 visits/benefit period Limit does not apply when Therapy services are prescribed for the treatment of Mental Health or Substance Abuse	
Respiratory Therapy	100%	80% after deductible
Speech Therapy	100% after $10 copay	80% after deductible
	Limit: 12 visits/benefit period Limit does not apply when Therapy services are prescribed for the treatment of Mental Health or Substance Abuse	
Occupational Therapy	100% after $10 copay	80% after deductible
	Limit: 12 visits/benefit period Limit does not apply when Therapy services are prescribed for the treatment of Mental Health or Substance Abuse	
Spinal Manipulations	100% after $10 copay	80% after deductible
	Limit: 30 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and 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 (includes virtual behavioral health visits)	100%	80% after deductible
Other Services		
Allergy Extracts and Injections	100%	80% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (7)	100%	80% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	100%	80% after deductible
Diabetic Supplies	100%	100% no deductible
Diabetic Treatment	100%	80% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
Contraceptive Devices, Implants and Injectables	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible
Elective Abortions includes Dependent Daughters	100%	80% after deductible
	Covered only in cases of rape, incest of to avert the death of the mother	
Hearing Care Services – includes evaluation, fitting, hearing aids, repair, and maintenance of the hearing aid.	100% up to $1,500 per ear maximum every 36 months Deductible does not apply	
Home Health Care	100%	80% after deductible
Hospice	100%	80% after deductible
Infertility Counseling, Testing and Treatment (8)	100%	80% after deductible
Private Duty Nursing	100%	80% after deductible
Skilled Nursing Facility Care	100%	80% after deductible
	Maximum of 100 days/benefit period	
Transplant Services	100%	80% after deductible
Precertification Requirements (9)	Yes	

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, and qualified medical expense. Prescription drug expenses are subject to a separate prescription drug TMOOP.
(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) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
(6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
(7) Services for the treatment of Autism Spectrum Disorders are covered for eligible members to age 21. After initial evaluation, Applied Behavioral Analysis will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g. speech therapy, diagnostic services). Treatment for Autism Spectrum Disorders does not reduce visit/day limits.
(8) 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.
(9) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification 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.

HIGHMARK.

An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator. If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you speak English, language assistance services, free of charge, are available to you. Call 1-888-269-8412.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-888-269-8412.

如果您说中文，可向您提供免费语言协助服务。
請致電 1-888-269-8412.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-888-269-8412.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-888-269-8412.

Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du 1-888-269-8412 uffrufe.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다.
1-888-269-8412 로 전화.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-888-269-8412.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-888-269-8412.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-888-269-8412.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-888-269-8412.

જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-888-269-8412 નંબર પર ફોન કરો.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-888-269-8412.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-888-269-8412.

បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ការហៅ 1-888-269-8412 ។

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-888-269-8412.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-888-269-8412.

日本語が母国語の方は言語アシスタンス・ サービスを無料でご利用いただけます。 1-888-269-8412 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان
با تماس با شماره 1-888-269-8412.

Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-888-269-8412.