Pennsylvania Judiciary Classic Blue Traditional Benefit Summary

Group #s 028623-00, -01, -03, -04

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	Hospital	Medical/Surgical	Major Medical
General Provisions			
Effective	January 1, 2025		
Benefit Period (1)	Calendar Year		
Deductible (per benefit period) Individual Family	 None None	 None None	 $100 $300
Plan Pays – payment based on the plan allowance	100% (Non-participating provider - 100% of charge for emergency services)	100%	80% after deductible (Non-participating provider - 80% RBM after deductible)
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family (Non-Aggregate)	 None None	 None None	 $480 $1,440
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 (Non-Aggregate)		 $580 $1,740	
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	Not Covered	Not Covered	80% after deductible
Primary Care Provider Office Visits	Not Covered	Not Covered	80% after deductible
Specialist Office & Virtual Visits	Not Covered	Not Covered	80% after deductible
Virtual Visit Originating Site Fee	Not Covered	Not Covered	80% after deductible
Urgent Care Center Visits	Not Covered	Not Covered	80% after deductible
Telemedicine Services (3)	Not Covered	Not Covered	80% after deductible
Preventive Care(4)			
Routine Adult Physical exams	 100%	 100%	 100% no deductible
Adult immunizations	100%	100%	100% no deductible
Colorectal cancer screening	100%	100%	100% no deductible
Routine gynecological exams, including a Pap test	100%	100%	100% no deductible
Breast Cancer Screenings (annual routine and supplemental)	100%	100%	100% no deductible
BRCA-Related Genetic Counseling and Genetic Testing	100%	100%	100% no deductible
Diagnostic services and procedures	100%	100%	100% no deductible
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 devices, flat or weak feet, chronic foot strain or symptomatic complaints of the feet.*	100%	100%	100% no deductible
Prostate Cancer Screening (Males Age 19 and over) - One Examination per Benefit Period	100%	100%	100% no deductible
Routine Pediatric Physical exams	 100%	 100%	 100% no deductible
Pediatric immunizations	100%	100%	100% no deductible
Diagnostic services and procedures	100%	100%	100% no deductible
Emergency Services			
Emergency Room Services	100% (Non-participating 100% of charge)	100%	80% after deductible
Ambulance – Emergency (ground/water/air)	100%	Not Covered	100% of charge for emergency transport
Ambulance – Non-Emergency (ground/water/air)	100%	Not Covered	80% after deductible
Hospital and Medical/Surgical Expenses (including Maternity)			
Hospital Inpatient	100%	100%	80% after deductible (private room $10 maximum per day)
Hospital Outpatient	100%	Not Covered	80% after deductible
Outpatient Surgery (facility)	100%	100%	80% after deductible
Surgical Services (professional) (except office visits) Includes Assistant Surgery, Anesthesia, Sterilization, Reversal Procedures and Neonatal Circumcision	Not Applicable	100%	80% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Maternity (non-preventive facility & professional services) Includes Dependent Daughter	100%	100%	80% after deductible
Medical Care (except office visits) Includes Inpatient Visits and Consultations	Not Applicable	100%	80% after deductible
Therapy and Rehabilitation Services			
Physical Medicine	100%	100%	80% after deductible
Outpatient	40 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	40 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	20 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse
Respiratory Therapy	100%	Not Covered	80% after deductible
Spinal Manipulations	Not Covered	100%	80% after deductible
		30 visits/benefit period	30 visits/benefit period
Speech & Occupational Therapy	100%	Not Covered	80% after deductible
Outpatient	12 visits per therapy/benefit period- limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse		12 visits per therapy/benefit period- limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse
Other Therapy Services - Cardiac Rehabilitation, Chemotherapy, Radiation Therapy, Dialysis and Infusion Therapy	100% (Cardiac Rehab: Not Covered)	100% (Cardiac Rehab & Infusion Therapy: Not Covered)	80% after deductible
Mental Health/Substance Abuse			
Inpatient Mental Health	100%	100%	80% after deductible
Inpatient Detoxification/Rehabilitation	100%	100%	Not Covered
Outpatient Mental Health	Not Covered	Not Covered	100% no deductible
Outpatient Substance Abuse	100%	Not Covered	80% after deductible
Other Services			
Allergy Extracts and Injections	Not Covered	Not Covered	80% after deductible
Autism Spectrum Disorders including Applied Behavior Analysis (5)	100%	100%	80% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered	Not Covered
Contraceptives Devices, Implants and Injectables	Not Covered	Not Covered	100% no deductible
Dental Services Related to Accidental Injury	Not Covered	Not Covered	80% after deductible
Diabetes Treatment			
Equipment and Supplies	Not Covered	Not Covered	100% of charge no deductible
Diabetes Education Program	100%	100%	80% after deductible
Diabetes Care Management Program (DCMP) – Digitally Monitored, includes telehealth consult for the A1C test	Not Covered	100% Continuous glucose monitor sprints are limited to three (3) per benefit period.	Not Covered
DCMP – All Other Telehealth Consults	Not Covered	100%	Not Covered
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	100%	80% after deductible
All Other Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	Not Covered	Not Covered	80% after deductible
Elective Abortions (includes dependent daughters)	100%	100%	80% after deductible
	Only for cases of rape, incest or to avert the mother's death		
Hearing Care Services – includes evaluation, fitting, hearing aids, repair and maintenance of the hearing aid	Not Covered	100% up to $1,500 per ear maximum every 36 months	Not Covered
Home Health Care (Excludes Respite Care)	100% 60 visits per 90 day period	Not Covered	80% after deductible
Hospice (Includes Respite Care)	100%	Not Covered	Not Covered
Infertility Counseling, Testing and Treatment (6)	100%	100%	80% after deductible
Oral Surgery	100%	100%	80% after deductible
Private Duty Nursing	Not Covered	Not Covered	80% after deductible Unlimited hours/benefit period
Skilled Nursing Facility Care	100% 100 days/benefit period	100%	80% after deductible
Transplant Services	100%	100%	80% after deductible
Precertification Requirements (7)	Yes	No	No

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 any qualified medical expense. Prescription drug expenses are subject to a separate prescription drug TMOOP.

(3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider.

Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(4) Services are limited to those listed on the Highmark Preventive Schedule with Enhancements (Women's Health Preventive Schedule may apply).
(5) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services-Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders 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). Services for the treatment of Autism Spectrum Disorders do 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) If you receive services from an out-of-area provider or a provider who does not participate with the local Blue Cross and/or Blue Shield plan, you must contact Highmark Utilization Management prior to a planned inpatient admission, 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.

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- 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 Claims Administrator/Insurer 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.

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ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

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توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.