Pennsylvania Judiciary PPO Blue

Group #s 028624-00, -01, -02, -03, -04, -05, -06

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		
Effective Date	January 1, 2027	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual Family	 None None	 $250 $500
Plan Pays – payment based on the plan allowance	100%	80% after deductible
Out-of-Pocket Limit (Includes coinsurance and prescription drug cost sharing. 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	 $5,600 $11,200	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $10 copay	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $10 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after $10 copay	80% after deductible
Virtual Visit Provider Originating Site Fee	100%	80% after deductible
Urgent Care Center Visits	100% after $10 copay	80% after deductible
	copay, if any, does not apply to urgent care center visits prescribed for the treatment of mental health or substance abuse	
On-Demand 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 Examination and Cervical Cancer Screenings	100%	80% (deductible does not apply)
Breast Cancer Screenings	100%	80% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100%	80% after deductible
Colorectal Cancer Screening	100%	80% after 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%	80% after deductible
Prostate Cancer Screening (Males Age 19 and over) One Examination per Benefit Period	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 (6)	100%	100% of Charge
Ambulance – Non-Emergency (6)	100%	80% after deductible
Hospital and Medical / Surgical Expenses (5)		
Hospital Inpatient	100%	80% after deductible
Hospital Outpatient	100%	80% after deductible
Outpatient Surgery (facility)	100%	80% after deductible
Surgical Services (professional) (except office visits) Includes Assistant Surgery, Anesthesia, Sterilization Reversal Procedures and Neonatal Circumcision	100%	80% after deductible
Maternity (non-preventive professional services) including dependent daughter	100%	80% after deductible
Medical Care (including inpatient visits and consultations)	100%	80% after deductible

Benefit	In Network	Out of Network
Therapy and Rehabilitation Services		
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	
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 limit does not apply when rehabilitative or habilitative speech therapy services are prescribed for the treatment of childhood stuttering	
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	
Respiratory Therapy	100%	80% after deductible
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 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 Applied Behavior Analysis (7)	100%	80% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury (10)	see service category (i.e. lab, surgery, imaging)	
Diabetes Treatment		
Equipment and Supplies	100%	80% (deductible does not apply)
Diabetes Education Program	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
Mammograms, Medically Necessary	100%	80% after deductible
Contraceptive Devices, Implants and Injectables	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible
Enteral Foods	100%	80% (deductible does not apply)
Elective Abortions - includes Dependent Daughters	100%	80% after deductible
	Covered only in cases of rape, incest or 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
Home Infusion and Suite Infusion Therapy	100%	80% after deductible
Hospice	100%	80% after deductible
Infertility Counseling, Testing and Treatment (8) (10)	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 (10)	100%	80% after deductible
Precertification/Authorization Requirements (9)	Yes	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 any deductibles, coinsurance, and copays. Prescription drug expenses are subject to a separate prescription drug TMOOP. If you are enrolled in a "Family plan", with your aggregate deductible, once an individual's deductible is satisfied, claim reimbursement for covered services will begin for that member. Once the family deductible is satisfied collectively by covered family members, claim reimbursement will begin for all covered family members. With your aggregate out-of-pocket limit, once an individual's out-of-pocket is satisfied, claim reimbursement for covered services will increase to 100% that member. Once the family out-of-pocket is satisfied collectively by covered family members, then 100% claim reimbursement for covered services will begin for all covered family members. With your aggregate TMOOP, once an individual's TMOOP is satisfied, claims will pay at 100% of the plan allowance for covered expenses for the rest of the benefit period. Claims for the remaining family members will pay at 100% once the family TMOOP amount is satisfied collectively.

(3) On-Demand 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) 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) 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.
(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.
(10) Covered Services will be covered according to the benefit category to which they apply (e.g. outpatient surgery, hospital inpatient, diagnostic services).

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Discrimination is Against the Law

The Claims Administrator/Insurer 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 Claims Administrator/Insurer 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 Claims Administrator/Insurer 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 Claims Administrator/Insurer 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 Claims Administrator/Insurer:

- 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.

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

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.

注： 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。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

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.