

Summary of PPOBlue NG Benefits

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.

County of Erie

010721-00,01,02,03,04,06,07,08,70,71,72,73,74,76,77,78

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period ⁽¹⁾	Calendar Year	
Deductible (per benefit period)		
Individual	\$100	\$200
Family	\$200	\$400
Plan Pays – payment based on the plan allowance	100%	80% after deductible
Out-of-Pocket Limits (Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	None	\$2,000
Family	None	\$4,000
Total Maximum Out of Pocket (Includes deductibles, copays, prescription drug cost sharing and other qualified medical expenses, Network only) ⁽²⁾ Once met, plan pays 100% of covered services for the rest of the benefit period.		Not Applicable
Individual	\$6,850	
Family	\$13,700	
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$20 copayment	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$20 copayment	80% after deductible Limit: 15 visits/benefit period
Specialist Office Visits & Virtual Visits	100% after \$20 copayment	80% after deductible
Urgent Care Center Visits	100% after \$20 copayment	80% after deductible
Telemedicine Service ⁽³⁾	100% after \$20 copayment	
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)
Mammograms, annual routine and 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
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient		
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services)		
Medical/Surgical (except office visits)		
Emergency Services		
Emergency Room Services	100% after \$75 copayment (waived if admitted)	
Ambulance -Emergency	100% after deductible	
Ambulance – Non Emergency	100%after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after \$20 copayment Limit: 25 visits per benefit period	Not covered
Respiratory Therapy	100%	
Speech & Occupational Therapy	100% after \$20 copayment	80% after deductible
	Limit: 25 visits per therapy/benefit period	
Spinal Manipulations	100% after \$20 copayment	80% after deductible
	Limit: 25 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%after deductible	80% after deductible

Mental Health/Substance Abuse		
Inpatient	100%after deductible	80% after deductible
Inpatient Detoxification/Rehabilitation	100%after deductible	80% after deductible
Outpatient	100%after deductible	80% after deductible
Other Services		
Allergy Extracts and Injections	100%after deductible	80% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	100%after deductible	80% after deductible
Diagnostic Services	100%after deductible	80% after deductible
<i>Advanced Imaging (MRI, CAT, PET scan, etc.)</i>	100%after deductible	80% after deductible
<i>Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</i>	100%after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%after deductible	80% after deductible
Home Health Care	100%after deductible	80% after deductible
Hospice	Not covered	
Infertility Counseling, Testing and Treatment⁽⁵⁾	Not covered	
Private Duty Nursing	100%after deductible	80% after deductible
	Limit: \$20,000 per benefit period	
Skilled Nursing Facility Care	100%after deductible	80% after deductible Limit: 100 days/benefit period
Transplant Services	100%after deductible	80% after deductible
Precertification Requirements⁽⁶⁾	Yes	
Prescription Drugs		
Prescription Drug Deductible	None	
Individual	None	
Family	None	
Prescription Drug Program⁽⁷⁾	Retail Drugs (34-day Supply) \$15 generic copayment \$25 brand copayment Maintenance Drugs through Mail Order (90-day Supply) \$30 generic copayment \$50 brand copayment	
Mandatory Generic		
<i>Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>		
<i>Your plan uses the Comprehensive Formulary.</i>		

- (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. Effective with plan years beginning on or after January 1, 2016, the TMOOP cannot exceed \$6,850 for individual and \$13,700 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. Gender, age and frequency limits may apply.
- (5) 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
- (6) 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 not, you are responsible for contacting MM&P. 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.
- (7) You are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.