HIGHMARK PPO Blue

LBT – Greencastle-Antrim School District
Active/Cobra/Retirees under 65 - effective 10/01/2019
Groups: 28759-10, -11, -12, -20, -21, -22, -30, -31 and -32

Summary of Benefits

This Summary of Benefits outlines your covered services.

Benefits	Network	Out-of-Network
General Provisions		
Benefit Period	Contract Year	
Deductible (per benefit period) Individual Family	 $1,500 $3,000	 $1,500 $3,000
Plan Payment Level - Based on the plan allowance	90% after deductible until out-of-pocket limit is met; then 100%	70% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limits Individual Family	 $500 $1,000	 $2,500 $5,000
Total Maximum Out-of-Pocket Individual Family	 $2,000 $4,000	 None None
Lifetime Maximum (per member)	Unlimited	
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits (including virtual visits)	100% after $20 copayment; deductible does not apply	70% after deductible
Primary Care Physician Office Visits (including virtual visits)[1 2]	100% after $20 copayment; deductible does not apply	70% after deductible
Specialist Office Visits (including virtual visits)[1]	100% after $35 copayment; deductible does not apply	70% after deductible
Virtual Visit Originating Site Fee[1]	90% after deductible	70% after deductible
Urgent Care Center Visits	100% after $35 copayment; deductible does not apply	70% after deductible
Telemedicine Services[3]	100% after $20 copayment; deductible does not apply	Not Covered
Preventive Care Services[4]		
Adult		
Routine physical exams	100%; deductible does not apply	70% after deductible
Adult Immunizations	100%; deductible does not apply	70% after deductible
Diagnostic services and procedures	100%; deductible does not apply	70% after deductible
Routine gynecological exams, including a PAP Test	100%; deductible does not apply	70%; deductible does not apply
Mammograms, annual routine and medically necessary	100%; deductible does not apply	70%; deductible does not apply
Pediatric		
Routine physical exams	100%; deductible does not apply	70% after deductible
Pediatric immunizations	100%; deductible does not apply	70%; deductible does not apply
Diagnostic services and procedures	100%; deductible does not apply	70% after deductible

9-13-19

Benefits	Network	Out-of-Network
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Services - Inpatient[6]	90% after deductible	70% after deductible
	Limit: 365 inpatient days;2 pint blood deductible/ per benefit period	
Hospital Services - Outpatient[5 6]	90% after deductible	70% after deductible
Maternity (non-preventive facility and professional services) Includes Dependent Daughters	90% after deductible	70% after deductible
Medical/Surgical Expenses (except office visits) Excludes Neonatal Circumcision	90% after deductible	70% after deductible
Emergency Services		
Emergency Room Services	100% after $150 copayment (waived if admitted as an inpatient or if combined with Observation Care); deductible does not apply	Same as network services
Emergency Ambulance Services	90%; deductible does not apply	90%; deductible does not apply
Non-Emergency Ambulance Services	90% after deductible	70% after deductible
Therapy and Rehabilitation Services		
Infusion Therapy	90% after deductible	70% after deductible
Occupational Therapy	100% after $35 copayment; deductible does not apply	70% after deductible
	Limit: 12 visits per benefit period	
Physical Medicine	100% after $35 copayment; deductible does not apply	70% after deductible
Radiation Therapy	90% after deductible	70% after deductible
Respiratory Therapy	90% after deductible	70% after deductible
Speech Therapy	100% after $35 copayment; deductible does not apply	70% after deductible
	Limit: 12 visits per benefit period	
Spinal Manipulations	100% after $35 copayment; deductible does not apply	70% after deductible
	Limit: 30 visits per benefit period	
Other Therapy Services (Cardiac Rehabilitation, Chemotherapy, and Dialysis Treatment)	90% after deductible	70% after deductible
Mental Health/Substance Abuse Services		
Mental Health Care Services - Inpatient	90% after deductible	70% after deductible
Mental Health Care Services - Outpatient (including virtual visits) [3]	100% after $35 copayment; deductible does not apply	70% after deductible
Substance Abuse Services - Inpatient Detoxification	90% after deductible	70% after deductible
Substance Abuse Services - Inpatient Residential Treatment and Rehabilitation Services	90% after deductible	70% after deductible
Substance Abuse Services - Outpatient	100% after $35 copayment; deductible does not apply	70% after deductible
Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Anesthesia for Non-Covered Dental Procedures (Limited)	90% after deductible	70% after deductible
Assisted Fertilization Treatment	Not Covered	
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible
Diabetes Treatment	90% after deductible	70% after deductible

Benefits	Network	Out-of-Network
Diagnostic Services *Advanced Imaging (*MRI, CAT Scan, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services • standard imaging • diagnostic medical • lab/pathology • allergy testing	90% after deductible	70% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible
Enteral Foods Exempt from all deductibles except for amino acid-based elemental medical formulae.	90%; deductible does not apply	70%; deductible does not apply
Home Infusion and Suite Infusion Therapy Services	90% after deductible	70% after deductible
Home Health Care[7]	90% after deductible	70% after deductible
	Limit: 90 visits per benefit period	
Hospice Includes Respite Care	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment[8]	90% after deductible	70% after deductible
Orthotics	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
	Limit: 240 hours per benefit period	
Prosthetics	90% after deductible	70% after deductible
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	Limit: 100 days per benefit period	
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements	Yes[9]	
Condition Management	Case Management, Blues on Call, and Disease State Management	

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during a benefit period will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

1 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 hospital, facility provider, ancillary provider, retail clinic or urgent care center. The specialist virtual visit is subject to availability within your service area.

2 A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.

3 Telemedicine services are provided for acute care for minor illnesses when provided by an approved telemedicine provider. Virtual behavioral health visits provided by an approved telemedicine provider are eligible under the outpatient mental health benefits.

4 Services are limited to those on a predefined schedule. Gender, age and frequency limits may apply.

5 Other cost sharing provisions and/or limits may apply to specific benefits, i.e., physical medicine, therapies, diagnostic services, mental health/substance abuse visits.

6 For covered services rendered by a facility provider within the service area who has no contractual relationship with Highmark, the plan allowance will be 60% of the facility provider's billed charge for inpatient services and 40% of the facility provider's billed charge for outpatient services. For covered services rendered by an out-of-area provider, such services will be priced by the local Blue Cross Blue Shield plan and submitted to Highmark via BlueCard. The plan allowance would then be subject to the coinsurance percentage after your deductible, if any, has been satisfied.

7 The maternity home health care visit for network care is not subject to the program copayment, coinsurance or deductible amounts, if applicable. See Maternity Home Health Care Visit in the Covered Services section.

8 If testing is required, cost sharing may apply as outlined under Diagnostic Services. 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 Highmark must be contacted prior to a planned inpatient admission or within 48 hours of an emergency inpatient admission. Some facility providers will contact Highmark and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting Highmark for precertification. If your provider does not, you are responsible for contacting Highmark. Also be sure to confirm Highmark's determination of medical necessity and appropriateness. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the patient will be responsible for payment of any costs not covered.

Prescription Drug Benefits	Retail Pharmacy Up to 30-days [1]	Mail Service Pharmacy Up to 90-days
Pharmacy Network	National	Express Scripts Pharmacy
Benefit Period	Contract Year	
Deductible (per benefit period)	None	None
Out of Pocket Limit	Not Applicable	
Generic Prescription Drug	80% plan payment/$75 maximum coinsurance per prescription	$10 copayment
Brand Prescription Drug	80% plan payment/$75 maximum coinsurance per prescription	$20 copayment
Formulary	Open	
Generic Substitution	Not Applicable	
Claim Submission	Pharmacy Files at Point-of-Sale	
Non-Network Pharmacy	Not Covered	Not Covered
Preventive Medications		
Preventive Covered Drugs[2]	Deductibles, coinsurance and/or copayments do not apply	
Prescription Drug Categories		
Fertility Agents	Covered	
Fluoride Products	Covered	
Insulin and Diabetic Supplies	Covered	
Vitamins (prescription)	Covered	
Weight Loss Drugs	Not Covered	
Prescription Hair Growth Products	Not Covered	
Care Management Programs		
Exclusive Pharmacy Provider	Applies – selected prescription drugs are eligible only when they are dispensed through an exclusive pharmacy provider.	
Quantity level Limits *on select prescription drugs*	Does Not Apply	
Managed R_x Coverage *on certain drug therapies*	Does Not Apply	
Managed Prior Authorizations	Does Not Apply	

[1] Certain retail participating pharmacy providers may have agreed to make covered medications available at the same cost-sharing and quantity limits as the mail order coverage. You may contact Highmark at the toll-free number or the Web site appearing on the back of your ID card for a listing of those pharmacies who have agreed to do so.

[2] This includes prescriptions and over-the-counter drugs that are set forth within the predefined schedule and that are prescribed for preventive purposes. Please refer to the Covered Services - Prescription Drug Program section for more information.