HIGHMARK. | PPO Blue

Lafayette College - PPO Standard – Customized PPO Blue Benefit Summary

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	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $800 $2,400	 $2,000 $6,000
Plan Pays – payment based on the plan allowance	85% after deductible	55% after deductible
Out-of-Pocket Limit - Coinsurance (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 $1,350 $4,050	 $4,000 $12,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing 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	 $6,600 $13,200	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $15 copay	55% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $15 copay	55% after deductible
Specialist Office & Virtual Visits	100% after $25 copay	55% after deductible
Virtual Visit Originating Site Fee	85% after deductible	55% after deductible
Urgent Care Center Visits	100% after $50 copay	55% after deductible
Telemedicine Services(3)	100% after $10 copay	Not Covered
Preventive Care(4)		
Routine Adult Physical exams	 100% (deductible does not apply)	 55% after deductible
Adult immunizations	100% (deductible does not apply)	55% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	55% (deductible does not apply)
Mammograms, annual routine	100% (deductible does not apply)	55% after deductible
Mammograms, medically necessary	100% (deductible does not apply)	55% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	55% after deductible
Routine Pediatric Physical exams	 100% (deductible does not apply)	 55% after deductible
Pediatric immunizations	100% (deductible does not apply)	55% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	55% after deductible
Emergency Services		
Emergency Room Services	100% after $100 copay (waived if admitted)	
Ambulance – Emergency	85% after network deductible	
Ambulance – Non-Emergency	85% after deductible	55% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	85% after deductible	55% after deductible
Hospital Outpatient	85% after deductible	55% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	85% after deductible	55% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	85% after deductible	55% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $25 copay Limit: Unlimited visits per therapy/benefit period	55% after deductible
Respiratory Therapy	85% after deductible	55% after deductible
Speech Therapy & Occupational Therapy	100% after $25 copay Limit: 30 visits/benefit period	55% after deductible
Spinal Manipulations	100% after $25 copay Limit: 20 visits/benefit period	55% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	85% after deductible	55% after deductible

Benefit	Network	Out-of-Network
Mental Health/Substance Abuse		
Inpatient Mental Health Services	85% after deductible	55% after deductible
Inpatient Detoxification / Rehabilitation	85% after deductible	55% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $25 copay	55% after deductible
Outpatient Substance Abuse Services	100% after $25 copay	55% after deductible
Other Services		
Allergy Extracts and Injections	85% after deductible	55% after deductible
Autism Spectrum Disorder including Applied Behavior Analysis(5)	85% after deductible	55% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	Not Covered	Not Covered
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	85% after deductible	55% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	85% after deductible	55% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	85% after deductible	55% after deductible
Home Health Care	85% after deductible	55% after deductible
	Limit: 90 visits/benefit period	
Hospice	85% after deductible	55% after deductible
Infertility Counseling, Testing and Treatment(6)	85% after deductible	55% after deductible
Private Duty Nursing	85% after deductible	55% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	85% after deductible	55% after deductible
	Limit: 100 days/benefit period	
Transplant Services	85% after deductible	55% after deductible
Precertification Requirements(7)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual Family	$250 $750	
Prescription Drug Out-of-Pocket	$4,250 Individual/benefit period $7,200 Family/Benefit period	
Prescription Drug Program(8) Hard Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.	**Retail Drugs (31/60/90-day Supply)** $10/$20/$30 generic copay $35/$70/$105 formulary brand copay $50/$100/$150 non-formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $20 generic copay $70 formulary brand copay $100 non-formulary brand copay	

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 Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.

(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.

(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) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does 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) 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 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.

(8) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the hard mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs.