HIGHMARK. Performance Flex Blue PPO

Hazleton Area SD Performance $500 Flex Blue PPO

Groups: 10822209,10822210,10822211,10822212,10822213,10822214,10822215,10822216,10822217,10822218,10822219 10822220,10822221,10822222,10822223,10822224

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out of pocket. 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
	Enhanced Value	Standard Value	
General Provisions			
Effective Date	01/01/2025		
Benefit Period (1)	Calendar Year		
Deductible (per benefit period) (All in-network services are credited to both the enhanced and the standard deductibles.)			
Individual	$250	$500	$1,000
Family	$750	$1,500	$3,000
Plan Pays/Coinsurance – payment based on the plan allowance	100% after deductible	100% after deductible	80% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) (All in-network services are credited to both the enhanced and the standard out-of-pocket limits.)			
Individual	None	None	None
Family	None	None	None
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copayments, 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	**$6,600**		Not Applicable
Family	**$13,200**		Not Applicable
Bi-Directional	CVS Caremark TMOOP		
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after $10 copayment	100% after $15 copayment	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $10 copayment	100% after $15 copayment	80% after deductible
Specialist Office Visits & Virtual Visits	100% after $15 copayment	100% after $30 copayment	80% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $15 copayment	100% after $30 copayment	80% after deductible
	copay, if any, does not apply to urgent care center visits prescribed for the treatment of mental health or substance abuse		
Telemedicine Services	Not Covered		Not Covered
Preventive Care(3)			
Routine Adult Physical Exams	100% (deductible does not apply)	100% (deductible does not apply)	80% after deductible
Adult immunizations	100% (deductible does not apply)	100% (deductible does not apply)	80% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Breast Cancer Screenings (annual routine and supplemental)	100% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	100% (deductible does not apply)	80% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Prostate Cancer Screening	100% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Nutritional Therapy	100% (deductible does not apply)	100% (deductible does not apply)	80% after deductible
	Benefit Limit: 6 visits/benefit period		
Diagnostic services and procedures	100% (deductible does not apply)	100% (deductible does not apply)	80% after deductible
Routine Pediatric Physical exams	100% (deductible does not apply)	100% (deductible does not apply)	80% after deductible
Pediatric immunizations	100% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	100% (deductible does not apply)	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)(5)			
Hospital Inpatient	100% after deductible	100% after deductible	80% after deductible
Hospital Outpatient (Non-Surgical)	100% after deductible	100% after deductible	80% after deductible
Outpatient Surgery (facility)	100% after deductible	100% after deductible	80% after deductible
Surgical Services (professional)	100% after deductible	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	100% after deductible	80% after deductible
Emergency Services			
Emergency Room Services (4)	100% after $100 copayment (waived if admitted)		
Ambulance – Emergency	100% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Ambulance – Non-Emergency (5)	80% after deductible	80% after deductible	80% after deductible
Therapy and Rehabilitation Services			
Physical Medicine	$15 copayment after deductible	$30 copayment after deductible	80% after deductible
	Benefit Limit: 45 visits/benefit period aggregate with speech therapy and occupational therapy-limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse		
Respiratory Therapy	100% after deductible	100% after deductible	80% after deductible
	Benefit Limit: 18 visits/benefit period		
Speech Therapy	$15 copayment after deductible	$30 copayment after deductible	80% after deductible
	Benefit Limit: 45 visits/benefit period aggregate with occupational therapy and physical medicine-limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse		
Occupational Therapy	$15 copayment after deductible	$30 copayment after deductible	80% after deductible
	Benefit Limit: 45 visits/benefit period aggregate with speech therapy and physical medicine-limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse		
Spinal Manipulations	100% after $5 copayment	100% after $15 copayment	80% after deductible
	Benefit Limit: 15 visits/benefit period no age limits		
Cardiac Rehabilitation Therapy	100% after deductible	100% after deductible	80% after deductible
	Benefit Limit: 36 visits/benefit period		
Other Therapy Services (Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	100% after deductible	80% after deductible
Mental Health/Substance Abuse			
Inpatient Mental Health Services	100% after deductible	100% after enhanced deductible	80% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	100% after enhanced deductible	80% after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	100% after deductible	100% after enhanced deductible	80% after deductible
Outpatient Substance Abuse	100% after deductible	100% after enhanced deductible	80% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	100% after deductible	80% after deductible
Applied Behavior Analysis for Autism Spectrum	100% after deductible	100% after deductible	80% after deductible

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Disorder (6)	**Benefit Limit:** $40,000 annual limit		
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	100% after deductible	100% after deductible	80% after deductible
Dental Services Related to Accidental Injury	100% after deductible	100% after deductible	80% after deductible
Diabetes Treatment Equipment and Supplies	100% after deductible	100% after deductible	80% after deductible
Diabetes Education Program	100% after deductible	100% after deductible	80% after deductible
Advanced Imaging (MRI, CAT, PET scan, etc.)	$75 copay after deductible	$75 copay after deductible	80% after deductible
	Benefit Limit: Copay is per test. The $75 copay does not apply to services provided by the following providers: Vision Imaging of Kingston-001655538, Imaging Associates of Hazleton-001317692, Schuylkill Imaging 005144427		
	copays, if any, do not apply to diagnostic services prescribed for the treatment of mental health or substance abuse		
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	100% after deductible	80% after deductible
Home Health Care	100% after $15 copay	$30 copayment after deductible	80% after deductible
	Benefit Limit: unlimited		
Hospice	100% after deductible	100% after deductible	80% after deductible
	Benefit Limit: 180 days/ lifetime and respite care maximum of 5 days for every 3 months		
Infertility Counseling, Testing and Treatment	100% after deductible	100% after deductible	80% after deductible
	Benefit Limit: Diagnostic services leading up to the diagnosis of infertility.		
Mammograms, Medically Necessary	100% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Private Duty Nursing	Not covered	Not covered	Not covered
Skilled Nursing Facility Care	100% after deductible		80% after deductible
	Benefit Limit: 100 days/benefit period		
Transplant Services	100% after deductible	100% after deductible	80% after deductible
Precertification/Authorization Requirements (7)	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 benefit summary.

**The terms "Enhanced Value" and "Standard Value" are not descriptors of the provider's ability.*

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, copayments, prescription drug cost share and any qualified medical expense.
3) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
4) 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.
5) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
6) 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.
7) 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.

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield, First Priority Health or First Priority Life, all of which are independent licensees of the Blue Cross Blue Shield Association.