HIGHMARK. PPO Blue

La Roche University Student Plan Summary of Benefits (Gold Metal Tier –82.51% Actuarial Value)

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.

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Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $250 $500	 $600 $1,200
Plan Payment Level – based on the plan allowance	80% after deductible	60% after deductible
Out-of-Pocket Limit (includes deductible and coinsurance; excludes copayments and prescription drug cost sharing) Once met, the plan pays 100% of covered medical and pediatric dental services for the rest of the benefit period. Individual Family	 $7,400 $14,800	 $10,000 $20,000
Total Maximum Out-of-Pocket(2) (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only. Once met, the plan pays 100% of covered services for the rest of the benefit period.) Individual Family	 $8,150 $16,300	 Not Applicable Not Applicable
Outpatient Medical Care Services		
Retail Clinic Visits (including Virtual Visits)	100% after $30 copayment	60% after deductible
Primary Care Provider Visits (including Virtual Visits)	100% after $30 copayment	60% after deductible
Specialist Visits (including Virtual Visits)	100% after $40 copayment	60% after deductible
Virtual Visit Originating Site Fee	80% after deductible	60% after deductible
Urgent Care Center Visits	100% after $50 copayment	60% after deductible
Telemedicine Services(3)	100% after $20 copayment	Not Covered
Preventive Care Services(4)		
Routine Physical exams (Adult & Pediatric)	100% no deductible	Not Covered
Adult immunizations	100% no deductible	60% after deductible
Colorectal cancer screenings	100% no deductible	60% after deductible
Routine gynecological exam and Pap Smear	100% no deductible	60% after deductible
Mammographic Screening	100% no deductible	60% after deductible
Routine Screening tests and procedures	100% no deductible	60% after deductible
Pediatric immunizations	100% no deductible	60% no deductible
Pediatric Vision(5) Exam (including dilation as professional indicated)	 100% no deductible	 Not Covered
Frames	100% no deductible	Not Covered
Lenses	100% no deductible	Not Covered
Pediatric Dental(5) Routine Exam, X-rays, Cleanings, Fluoride Treatments, Palliative Treatment (emergency), Sealants and Space Maintainers	 100% no deductible	 Not Covered
Other Pediatric Dental Services(6)	50% no deductible	Not Covered
Emergency Room and Ambulance Services		
Emergency Room Services	80% after $150 copayment (waived if admitted)	
Ambulance – Emergency(11)	100% no deductible	
Ambulance – Non-Emergency(11)	80% after deductible	60% after deductible
Hospital and Medical/Surgical Services (including maternity)		
Hospital Inpatient(7)	80% after deductible	60% after deductible
Hospital Outpatient	80% after deductible	60% after deductible
Maternity (non-preventive facility & professional services)	80% after deductible	60% after deductible
Inpatient Medical Care Services, Surgical Services	80% after deductible	60% after deductible

Therapy, Habilitative and Rehabilitative Services		
Physical Medicine[8]	80% after deductible	60% after deductible
	Limit: 30 visits/benefit period each for Habilitative and Rehabilitative	
Speech Therapy[8]	80% after deductible	60% after deductible
	Limit: 30 visits/benefit period each for Habilitative and Rehabilitative	
Occupational Therapy[8]	80% after deductible	60% after deductible
	Limit: 30 visits/benefit period each for Habilitative and Rehabilitative	
Spinal Manipulations	80% after deductible	60% after deductible
	Limit: 20 visits/benefit period	
Cardiac Rehabilitation	80% after deductible	60% after deductible
Home Infusion and Suite Infusion Therapy	80% after deductible	60% after deductible
Other Therapy Services (Chemotherapy, Dialysis, Infusion Therapy, Pulmonary Therapy, Radiation Therapy, Respiratory Therapy)	80% after deductible	60% after deductible
Mental Health/Substance Abuse Services		
Inpatient[7]	80% after deductible	60% after deductible
Outpatient	100% after $40 copayment	60% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	60% after deductible
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diagnostic Services *Advanced Imaging* (CT, CTA, MRI, MRA, PET scan, PTE/CT scan, etc.)	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
	Respite Care is limited to 7 days every six (6) consecutive months	
Private Duty Nursing	80% after deductible	60% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Services	80% after deductible	60% after deductible
Therapeutic Injections	80% after deductible	60% after deductible
Transplant Services	80% after deductible	60% after deductible
Prescription Drugs		
Deductible Individual Family	None None	
Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the HCR Comprehensive Formulary[9] Hard Mandatory Generic[10]	**Retail Drugs (31-day Supply)** $25 generic copayment $45 formulary brand copayment $60 non-formulary brand copayment **Maintenance Drugs through Mail Order (90-day Supply)** $62 generic copayment $112 formulary brand copayment $150 non-formulary brand copayment	

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your school's effective date. Contact your school 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 must be performed by a Highmark approved telemedicine provider.
(4) Services are limited to those listed on the Highmark Preventive Schedule and Women's Health Preventive Schedule.
(5) Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.
(6) A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality. Prior approval is required. See your benefit booklet for more details.
(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 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.
(8) Limit does not apply to Habilitative services for the treatment of a Mental Health or Substance Abuse diagnosis.
(9) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for formulary drugs at the specific copayment or coinsurance amounts listed above.
(10) Under the hard mandatory generic provision, you are responsible for the payment differential when a generic drug is available and you or your provider specifies a brand name drug. Your payment is the price difference between the brand name drug and the generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.
(11) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits