HIGHMARK. | PPO Blue

State College Area School District - QHDHP Benefit Summary

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). 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. If you enroll as an individual, the deductible and out-of-pocket maximums for the "Employee Only Plan" apply. If you enroll as a family, the deductible and out-of -pocket maximums for the "Family Plan" apply and can be satisfied by one or more of your family members.

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Employee Only Plan Family Plan	 $1,500 $3,000	 $3,000 $6,000
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible
Out-of-Pocket Limit (Includes prescription drug expenses, coinsurance and copay. Once met, plan pays 100% coinsurance for the rest of the benefit period) Employee Only Plan Family Plan	 $1,500 $3,000	 $3,000 $6,000
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. Employee Only Plan Family Plan	 $3,000 $6,000	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $25 copay after deductible	70% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $25 copay after deductible	70% after deductible
Specialist Office & Virtual Visits	100% after $25 copay after deductible	70% after deductible
Virtual Visit Originating Site Fee	100% after deductible	70% after deductible
Urgent Care Center Visits	100% after $50 copay after deductible	70% after deductible
Telemedicine Services(3)	100% after $20 copay after deductible	
Preventive Care(4)		
Routine Adult Physical exams	 100% (deductible does not apply)	 70% after deductible
Adult immunizations	100% (deductible does not apply)	70% after deductible
Colorectal cancer screening	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	100% (deductible does not apply)	70% after deductible
Mammograms, medically necessary	100% after deductible	70% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	70% after deductible
Routine Pediatric 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
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	70% after deductible
Hospital Outpatient	100% after deductible	70% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	70% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	70% after deductible
Emergency Services		
Emergency Room Services	100% after $100 copay after network deductible (copay waived if admitted)	
Ambulance	100% after network deductible	
Ambulance – Non-Emergency	100% after deductible	70% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $25 copay after deductible Limit: 30 visits/benefit period	70% after deductible
Respiratory Therapy	100% after deductible	70% after deductible
Speech & Occupational Therapy	100% after $25 copay after deductible Limit: 30 visits per therapy/benefit period	70% after deductible
Spinal Manipulations	100% after $25 copay after deductible Limit: 20 visits/benefit period	70% after deductible

Benefit	Network	Out-of-Network
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible
Mental Health/Substance Abuse		
Inpatient	100% after deductible	70% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	70% after deductible
Outpatient (includes virtual behavioral health visits)	100% after $25 copay after deductible	70% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	70% after deductible
Autism Spectrum Disorder including Applied Behavior Analysis(5)	100% after deductible	70% 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.)	100% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	70% after deductible
Home Health Care	100% after deductible	70% after deductible
	Limit: 90 visits/benefit period	
Hospice	100% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment(6)	100% after deductible	70% after deductible
Private Duty Nursing	100% after deductible	70% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after deductible	70% after deductible
	Limit: 100 days/benefit period	
Transplant Services	100% after deductible	70% after deductible
Precertification Requirements(7)	YES	
Prescription Drugs		
Prescription Drug Deductible Individual Family	 Integrated with medical deductible Integrated with medical deductible	
Prescription Drug Program(8) Soft 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)** 90% Generic Plan Payment after plan deductible 75% Brand Formulary Plan Payment after plan deductible 70% Brand Non-Formulary Plan Payment after plan deductible ***Maintenance Drugs through Mail Order (90-day Supply)*** $10 Generic Copay after plan deductible $30 Brand Formulary Copay after plan deductible $50 Brand Non-Formulary Copay after plan deductible	
Specialty Pharmacy (30 day supply)	$3 Generic Copay after plan deductible $10 Brand Formulary Copay after plan deductible $16 Brand Non-Formulary Copay after plan deductible	

(1) Your group's benefit period is based on a Calendar Year.
(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 $6,550 for individual and $13,100 for two or more persons. In addition, new regulations for 2016 do not allow a member within a family plan to exceed $6,850 in cost sharing.
(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 Outpatient Mental Health/Substance Abuse benefit.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits 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) At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled.