HIGHMARK. Performance Flex Blue PPO

Performance Flex Blue PPO

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	In-Network Enhanced Value	In-Network Standard Value	Out of Network
General Provisions			
Effective Date	July 1, 2022		
Benefit Period (1)	Contract Year		
Deductible (per benefit period) Individual Family	 None None	 $1,200 $2,400	 $2,000 $4,000
Plan Pays – payment based on the plan allowance	100%	80% after deductible	50% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 $4,000 $8,000	 $8,000 $16,000
Office/Clinic/Urgent Care Visits			
Primary Care Provider Office Visits & Virtual Visits	100% after $0 copay	100% after $20 copay	50% after deductible
Specialist Office Visits & Virtual Visits	100% after $10 copay	100% after $50 copay	50% after deductible
Retail Clinic Visits & Virtual Visits	100% after $5 copay	100% after $40 copay	50% after deductible
Virtual Visit Provider Originating Site Fee	100%	80% after deductible	50% after deductible
Urgent Care Center Visits	100% after $10 copay	100% after $40 copay	50% after deductible
Telemedicine Services (5)	100% after $0 copay	100% after $20 copay	not covered
Preventive Care (2)			
Routine Adult Physical Exams	100%	100% (deductible does not apply)	50% after deductible
Adult Immunizations	100%	100% (deductible does not apply)	50% after deductible
Colorectal cancer screening	100%	100% (deductible does not apply)	50% after deductible
Routine Gynecological Exams, including a Pap Test	100%	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms, Annual Routine	100%	100% (deductible does not apply)	50% after deductible
Mammograms, Medically Necessary	100%	100% (deductible does not apply)	50% after deductible
Diagnostic Services and Procedures	100%	100% (deductible does not apply)	50% after deductible
Routine Pediatric Physical Exams	100%	100% (deductible does not apply)	50% after deductible
Pediatric Immunizations	100%	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic Services and Procedures	100%	100% (deductible does not apply)	50% after deductible
Emergency Services			
Emergency Room Services (6)	100% after $100 copay (waived if admitted)		
Ambulance – Emergency (7)	100% (deductible does not apply)		
Ambulance - Non-Emergency (7)	100% (deductible does not apply)		
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	100%	80% after deductible	50% after deductible
Hospital Outpatient	100%	80% after deductible	50% after deductible

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Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
Maternity (non-preventive facility & professional services) including dependent daughter	100%	80% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100%	80% after deductible	50% after deductible
Therapy and Rehabilitation Services			
Physical Medicine	100%	100% after deductible	50% after deductible
Respiratory Therapy	100%	80% after deductible	50% after deductible
Speech Therapy	100%	100% after deductible	50% after deductible
Occupational Therapy	100%	100% after deductible	50% after deductible
Spinal Manipulations	100% after $25 copay	100% after $50 copay	50% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible	50% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	100%	100% (deductible does not apply)	50% after deductible
Inpatient Detoxification / Rehabilitation	100%	100% (deductible does not apply)	50% after deductible
Outpatient - includes virtual behavioral health visits	100%	100% (deductible does not apply)	50% after deductible
Other Services			
Allergy Extracts and Injections	100%	80% after deductible	50% after deductible
Assisted Fertilization Procedures	100%	80% after deductible	50% after deductible
	Benefit maximum of $5,000/family/lifetime		
Dental Services Related to Accidental Injury	100%	80% after deductible	Not Covered
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	80% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible	50% after deductible
Home Health Care	100%	80% after deductible	50% after deductible
Hospice	100%	100% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (3)	100%	80% after deductible	50% after deductible
Private Duty Nursing	100% (deductible does not apply)		
Skilled Nursing Facility Care	100%	80% after deductible	50% after deductible
Transplant Services	100%	100% after deductible	50% after deductible
Precertification/Authorization Requirements (4)	Yes	Yes	Yes

Questions? Call 1-800-215-7865

Reference Code: P0040222

(Please have your Reference Code ready when you call.)

(1) Your group's benefit period is based on a Contract Year. The contract year is a consecutive 12-month period, beginning July 1st and ending June 30th.

(2) Services are limited to those listed on the Highmark Preventive Schedule. (Women's Health Preventive Schedule may apply).

(3) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Treatment does not include Assisted Fertilization Procedures.

(4) Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of a maternity related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. 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.

(5) 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.

(6) 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.

(7) Benefits for Ambulance Services provided by air and rendered by an Out-of-Network provider and/or Emergency Ambulance Services rendered by an Out-of-Network Provider, will be paid at the network level and are subject to the deductible amount, if any, that is applicable to network services. 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.

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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.

The terms "enhanced value" and "standard value" are not descriptors of the provider's ability. This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy / plan documents, as limitations and exclusions may apply. The policy / plan documents control in the event of a conflict with this benefit summary. The benefit grid has numerous benefits listed at 100% paid. This can include; hospitals, doctors, ambulance, therapies/physical medicine, mental health, durable medical equipment, etc. to name a few. However, that 100% paid is 100% of Highmark's allowance. The important fact is Highmark is paying 100% of an allowance not 100% of the billed charge. If your provider is participating in-network at the Enhanced tier they should accept our 100% payment as payment in full minus any benefit copay. However, if your provider is out of network or non-participating, they may bill you for balance bills which you will be responsible for. You pay the least if you use a provider in the Enhanced Network. You pay more if you use a provider in the Standard Network. You will pay the most if you use an out-of-network provider, and you may receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).

Special COVID-19 Coverage Variations.

To the extent required by law your program will provide the following at no cost to you:

- Coverage for items and services furnished during healthcare provider office visits (which includes in-person visits and telemedicine visits) that result in an order for or administration of an in vitro diagnostic product, but only to the extent the items and services relate to the furnishing or administration of the product or to the evaluation of the individual for purposes of determining the need for such product.
- Coverage for the above required items and services that are furnished by providers that have not agreed to accept a negotiated rate as payment in full (i.e., out-of-network providers).
- Coverage for the above required items and services in both traditional and non-traditional health care settings; including telehealth.

In addition, your plan will cover in-patient care at an in-network hospital for COVID-19 treatment without member cost-sharing. This benefit is subject to change at the determination of the ACSHIC Board of Trustees.

Please note, that Performance Blue products including Performance Flex Blue, are high performing network products and those products do not provide full access to all UPMC providers. Please reference separate materials, the Highmark website, or call Highmark Concierge at 1-877-258-3123 to determine which UPMC providers are in and out of network.

HIGHMARK.

An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.