HIGHMARK. Performance Blue PPO

Performance Blue PPO

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	In Network	Out of Network
General Provisions		
Effective Date	July 1, 2025	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 $200 $400	 $2,500 $5,000
Plan Pays – payment based on the plan allowance	100% 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	 N/A N/A	 $9,000 $18,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, 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	 $9,450 $18,900	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Primary Care Provider Office Visits & Virtual Visits (3)	100% after $0 copay	50% after deductible
Specialist Office Visits & Virtual Visits	100% after $20 copay	50% after deductible
Retail Clinic Visits & Virtual Visits	100% after $15 copay	50% after deductible
Virtual Visit Provider Originating Site Fee	100% after $0 copay	50% after deductible
Urgent Care Center Visits	100% after $20 copay	50% after deductible
Telemedicine Services (4)	100% after $0 copay	not covered
Preventive Care (5)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 50% after deductible
Adult Immunizations	100% (deductible does not apply)	50% after deductible
Colorectal cancer screening	100% (deductible does not apply)	50% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	50% after deductible
Mammograms, Annual Routine	100% (deductible does not apply)	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 50% after deductible
Pediatric Immunizations	100% (deductible does not apply)	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	50% after deductible
Emergency Services		
Emergency Room Services (6)	100% after $125 copay (waived if admitted)	
Ambulance – Emergency (7)	100% after deductible	
Ambulance - Non-Emergency (7)	100% after deductible	
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	50% after deductible
Therapy and Rehabilitation Services		

Benefit	In Network	Out of Network
Physical Medicine	100% after deductible	50% after deductible
Respiratory Therapy	100% after deductible	50% after deductible
Speech Therapy	100% after deductible	50% after deductible
Occupational Therapy	100% after deductible	50% after deductible
Spinal Manipulations	100% after $25 copay	50% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	50% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	50% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after deductible	50% after deductible
Outpatient Substance Abuse Services	100% after deductible	50% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	50% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (8)	100% after deductible	50% after deductible
Assisted Fertilization Procedures	100% after deductible	50% after deductible
	Benefit maximum of $5,000/family/lifetime	
Dental Services Related to Accidental Injury	100% after deductible	Not Covered
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	50% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	50% after deductible
Home Health Care	100% after deductible	50% after deductible
Hospice	100% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (9)	100% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	50% after deductible
Skilled Nursing Facility Care	100% after deductible	50% after deductible
Transplant Services	100% after deductible	50% after deductible
Precertification/Authorization Requirements (10)	Yes	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 benefits summary.

Questions? Call 1-844-946-6238

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)The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government, TMOOP must include deductible, coinsurance, copays, and any qualified medical expense.
(3) Cost sharing does not apply to in network outpatient visits for covered mental health or substance abuse services.
(4)Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(5) Services are limited to those listed on the Highmark Preventive Schedule. (Women's Health Preventive Schedule may apply).