HIGHMARK. Performance Blue EPO

# Performance Blue EPO

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 |
|---|---|
| **General Provisions** | |
| Effective Date | July 1, 2025 |
| Benefit Period (1) | Contract Year |
| Deductible (per benefit period)<br>Individual<br>Family | <br>$200<br>$400 |
| Plan Pays – payment based on the plan allowance | 100% after deductible |
| Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period)<br>Individual<br>Family | <br>N/A<br>N/A |
| 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.<br>Individual<br>Family | <br><br><br>$9,450<br>$18,900 |
| **Office/Clinic/Urgent Care Visits** | |
| Primary Care Provider Office Visits & Virtual Visits (3) | 100% after $0 copay |
| Specialist Office Visits & Virtual Visits | 100% after $20 copay |
| Retail Clinic Visits & Virtual Visits | 100% after $15 copay |
| Virtual Visit Provider Originating Site Fee | 100% after $0 copay |
| Urgent Care Center Visits | 100% after $20 copay |
| Telemedicine Services (4) | 100% after $0 copay |
| **Preventive Care (5)** | |
| **Routine Adult**<br>Physical Exams | <br>100% (deductible does not apply) |
| Adult Immunizations | 100% (deductible does not apply) |
| Colorectal cancer screening | 100% (deductible does not apply) |
| Routine Gynecological Exams, including a Pap Test | 100% (deductible does not apply) |
| Mammograms, Annual Routine | 100% (deductible does not apply) |
| Diagnostic Services and Procedures | 100% (deductible does not apply) |
| **Routine Pediatric**<br>Physical Exams | <br>100% (deductible does not apply) |
| Pediatric Immunizations | 100% (deductible does not apply) |
| Diagnostic Services and Procedures | 100% (deductible does not apply) |
| **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 |
| Hospital Outpatient | 100% after deductible |
| Maternity (non-preventive facility & professional services) including dependent daughter | 100% after deductible |
| Medical Care (including inpatient visits and consultations)/Surgical Expenses | 100% after deductible |
| **Therapy and Rehabilitation Services** | |
| Physical Medicine | 100% after deductible |
| Respiratory Therapy | 100% after deductible |
| Speech Therapy | 100% after deductible |
| Occupational Therapy | 100% after deductible |

| Benefit | In Network |
|---|---|
| Spinal Manipulations | 100% after $25 copay |
| Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) | 100% after deductible |
| **Mental Health / Substance Abuse** | |
| Inpatient Mental Health Services | 100% after deductible |
| Inpatient Detoxification / Rehabilitation | 100% after deductible |
| Outpatient Mental Health Services (includes virtual behavioral health visits) | 100% after deductible |
| Outpatient Substance Abuse Services | 100% after deductible |
| **Other Services** | |
| Allergy Extracts and Injections | 100% after deductible |
| Autism Spectrum Disorder Applied Behavior Analysis (8) | 100% after deductible |
| Assisted Fertilization Procedures | 100% after deductible<br>Benefit maximum of $5,000/family per lifetime |
| Dental Services Related to Accidental Injury | 100% after deductible |
| **Diagnostic Services**<br>Advanced Imaging (MRI, CAT, PET scan, etc.) | 100% after deductible |
| Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing) | 100% after deductible |
| Durable Medical Equipment, Orthotics and Prosthetics | 100% after deductible |
| Mammograms, Medically Necessary | 100% (deductible does not apply) |
| Home Health Care | 100% after deductible |
| Hospice | 100% after deductible |
| Infertility Counseling, Testing and Treatment (9) | 100% after deductible |
| Private Duty Nursing | 100% after deductible |
| Skilled Nursing Facility Care | 100% after deductible |
| Transplant Services | 100% after deductible |
| Precertification/Authorization Requirements (10) | 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: P0050222**

*(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).
(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.
(8)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