Summary of PPOBlue

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.

Western PA Teamsters' and Employers' Welfare Fund – 9AC

Benefit	Network	Out-of-Network (7)
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual Family ** If you do not complete an annual physical exam and appropriate biometric testing you will be charged an additional $200 individual deductible and a $400 family deductible	 None None	 $250 $500
Plan Pays – payment based on the plan allowance	100%	60% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period. The deductible is excluded from the Out-of-Pocket) (6) Individual Family	 None None	 $1,000 $2,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $20 copayment	60% after deductible
Primary Care Provider Office Visits	100% after $20 copayment	60% after deductible
Specialist Office Visits	100% after $30 copayment	60% after deductible
Virtual Visit Originating Site Fee	100%	60% after deductible
Urgent Care Center Visits	100% after $30 copayment	60% after deductible
Telemedicine Service	100% after $10 copayment	
Preventive Care(2)		
Routine Adult Physical exams	 100%	 Not Covered
Adult immunizations	100%	60% after deductible
Colorectal cancer screening	100%	60% after deductible
Routine gynecological exams, including a Pap Test	100%	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	60% after deductible
Diagnostic services and procedures	100%	60% after deductible
Routine Pediatric Physical exams	 100%	 Not Covered
Pediatric immunizations	100%	60% (deductible does not apply)
Diagnostic services and procedures	100%	60% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient **Hospital Outpatient** **Maternity** (non-preventive facility & professional services) **Medical/Surgical** (except office visits)	100%	60% after deductible
Emergency Services		
Emergency Room Services	100% after $100 copayment (waived if admitted)	
Ambulance	100%	
Therapy and Rehabilitation Services		
Physical Medicine	100% after $20 copayment	60% after deductible
Respiratory Therapy	100%	60% after deductible
Speech & Occupational Therapy	100% after $20 copayment	60% after deductible
Spinal Manipulations	100% after $20 copayment	60% after deductible Limit: 25 visits/benefit period
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	60% after deductible
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	100%	60% after deductible
Outpatient	100% after $20 copayment	60% after deductible
Other Services		
Allergy Extracts and Injections	100%	60% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	100%	60% after deductible

Benefit	Network	Out-of-Network (7)
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	60% after deductible
Home Health Care	100%	60% after deductible Limit: 50 days/benefit period
Hospice	100%	60% after deductible
Infertility Counseling, Testing and Treatment(3)	100%	60% after deductible
Private Duty Nursing	100%	60% after deductible Limit: $5000 /benefit period
Skilled Nursing Facility Care	100%	60% after deductible Limit: 50 days/benefit period
Transplant Services	100%	60% after deductible
Precertification Requirements(4)	Yes	
Prescription Drugs		
Prescription Drug Program(5) Mandatory Generic *Defined by the National Plus Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary.*	**Retail Drugs (30-day Supply)** generic copayment $10 formulary brand copayment $25 non-formulary brand copayment $50 **Maintenance Drugs through Mail Order (90-day Supply)** generic copayment $20 formulary brand copayment $50 non-formulary brand copayment $100	

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(2) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.

(3) 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.

(4) 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.

(5) 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 both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above.You are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

(6) Effective with plan years beginning on or after January 1,2014 the Network Total Maximum Out-of-Pocket as mandated by the federal government must include deductible, coinsurance, copays, and any qualified medical expenses. The Total Maximum Out of Pocket cannot be more than $7,900 for individual and $15,800 for two or more persons

(7) For out of network services, you may be responsible for paying any difference between the provider's actual charge and the Community Blue allowable charge. Out of pocket limits do not apply to these types of member payments.

This grid is for Group Numbers