Washington & Jefferson College (Union Contracts)

Overview of PPOBlue Medical Plan

Non-Grandfathered

BENEFIT	PPOBlue Medical Plan Group Numbers: 12765-08 (Active) & 12765-78 (Inactive) In-Network Care[1]	Out-of-Network Care[1, 2]
Policy Provisions		
Benefit Period	Calendar Year	
Calendar Year Deductible (Individual/Family)[3]	$1,500 / $3,000	$3,000 / $6,000
Coinsurance (The Plan Pays:)[3]	80% after deductible until annual out-of-pocket limit is met, then 100%	50% after deductible
Annual Out-of-Pocket Limit[3] (Individual/Family)	$2,500 / $5,000 (not including deductibles)	Not Applicable
Lifetime Maximum per Person	Unlimited	
Total Maximum Out-of-Pocket (Individual/Family)[5] (Includes medical & prescription drug deductible, coinsurance, & copays)	$6,850 / $13,700	Not Applicable
Dependent Eligibility	Dependents to age 26	
Precertification Requirements	Yes (provider responsibility)	Yes[6]
Preventive Care Services		
Routine Physical Exams (Adult & Pediatric)	100% (deductible does not apply)	Not Covered
Routine Annual Gynecological Exams, including PAP Smear	100% (deductible does not apply)	50% (deductible does not apply)
Adult Immunizations	100% (deductible does not apply)	50% after deductible
Childhood Immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms - Routine	100% (deductible does not apply)	50% after deductible
Colorectal Cancer Screening - Routine	100% (deductible does not apply)	50% after deductible
Hospital / Physician Services		
Physician Office Visits	100% after $25 copay per visit	50% after deductible
Specialist Office Visits	100% after $40 copay per visit	50% after deductible
Telemedicine Services[7]	100% after $10 copay per visit	Not Covered
Maternity Care	80% after deductible	50% after deductible
Inpatient Hospital Services	80% after deductible	50% after deductible
Outpatient Hospital Services	80% after deductible	50% after deductible
Medical/Surgical Services (Except Office Visit)	80% after deductible	50% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT Scan, PET Scan, etc)	100% after $20 copay per date of service per provider	50% after deductible
Basic Diagnostic Services (Standard Imaging, Diagnostic Medical, Lab/Pathology, Allergy Testing)	100% after $20 copay per date of service per provider	50% after deductible
Mammograms - Medically Necessary	100% (deductible does not apply)	50% after deductible
Colorectal Cancer Screening - Medically Necessary	80% after deductible	50% after deductible
Allergy Extracts	80% after deductible	50% after deductible
Transplant Services	80% after deductible	50% after deductible
Emergency Services		
Emergency Room Services[8]	100% after $100 copay per visit (waived if admitted) *Notes: If inpatient admission occurs, deductible will apply. If outpatient observation occurs, copay will apply.*	
Ambulance	80% after deductible	
Therapy Services		
Spinal Manipulation Services	100% after $40 copay per visit *Notes: 1) Specialist office visit copay may apply, if an office visit is billed. 2) If your chiropractor bills physical therapy services and spinal manipulations, copayments will apply to the physical therapy services.*	50% after deductible
	Combined Limit: 10 Visits Per Benefit Period	
Physical, Speech, & Occupational Therapy Services	100% after $40 copay per visit *Specialist office visit copay may apply, if an office visit is billed*	50% after deductible
	Combined Limit: 30 Visits Per Benefit Period Per Therapy Type	
Cardiac Rehabilitation, Chemotherapy, & Dialysis Treatment	80% after deductible	50% after deductible
Infusion, Radiation, & Respiratory Therapy Services	80% after deductible	50% after deductible

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Behavioral Health Services		
Mental Health - Inpatient	80% after deductible	50% after deductible
Mental Health - Outpatient	100% (deductible does not apply)	50% after deductible
Substance Abuse - Inpatient Detoxification	80% after deductible	50% after deductible
Substance Abuse - Inpatient Rehabilitation	80% after deductible	50% after deductible
Substance Abuse - Outpatient Rehabilitation	100% (deductible does not apply)	50% after deductible
Other Services		
Dental Services Related to Accidental Injury	80% after deductible	50% after deductible
Diabetes Treatment	80% after deductible	50% after deductible
Durable Medical Equipment, Orthotics, and Prosthetics	80% after deductible	50% after deductible
Enteral Formulae	80% (deductible does not apply)	50% (deductible does not apply)
Home Infusion Therapy	80% after deductible	50% after deductible
Home Health Care	80% after deductible	50% after deductible
Hospice Care	80% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment[9]	80% after deductible	50% after deductible
Orthotics	80% after deductible	50% after deductible
Pediatric Extended Care Services	80% after deductible	50% after deductible
	Combined Limit: 100 Days Per Benefit Period	
Private Duty Nursing	80% after deductible	50% after deductible
	Combined Limit: $10,000 Maximum Per Benefit Period	
Prosthetics	80% after deductible	50% after deductible
Skilled Nursing Facility	80% after deductible	50% after deductible
Prescription Drugs		
Prescription Drug Deductible	$100 Individual / $200 Family Aggregate[10] *Combined retail and mail order* *Deductible must be satisfied before copays apply*	
Prescription Drugs - Retail	$5 Generic / $45 Brand Formulary / $60 Brand Non-Formulary Copays Up to a 31 day supply Premier 2012 Pharmacy Network Choice Formulary with Soft Mandatory Generic Provision[11]	
Prescription Drugs - Mail Order	$5 Generic / $45 Brand Formulary / $60 Brand Non-Formulary Copays Up to a 90 day supply Choice Formulary with Soft Mandatory Generic Provision[11]	

[1] 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

[2] Precertification may be required for services rendered by Out-of-Network Providers.

[3] Does not apply to prescription drug benefits.

[4] Non-participating providers or those who are not in the Highmark network can bill members for the difference between the amount that the non-participating provider bills and the payment Highmark will make for the covered services that are performed by the non-participating provider. This is referred to as balance billing and the member's liability is not limited by the health plan. Balance billing liabilities are above and beyond the out-of-pocket maximum listed on this benefit grid.

[5] The in-network total maximum out-of-pocket as mandated by the federal government must include medical and prescription drug deductible, coinsurance, & copays.

[6] HMS must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or 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 incurred.

[7] Services must be performed by a Highmark approved telemedicine provider.

[8] Emergency service is any health care service provided to a member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the health of the member, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

[9] 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.

[10] The deductible is a specified dollar amount you must pay for covered medications each benefit period before the plan begins to provide payment for covered medications. For a family with several covered dependents, the deductible you pay for all covered family members, regardless of family size, is specified under the family deductible. To reach this total, you can count the expenses incurred by two or more covered family members. However, the deductible contributed towards the total by any one covered family member will not be more than the amount of the individual deductible. If one family member meets the individual deductible and needs to use benefits, the program would begin to pay for that person's covered expenses even if the deductible for the entire family has not been met.

[11] Under the Soft Mandatory Generic Provision, the member is responsible for the payment differential when a generic drug is available and the **patient** elects to purchase a brand name drug. The member payment is the price difference between the generic and the brand name, in addition to copayment or coinsurance amounts which apply.

NOTE: This grid is provided as an overview of benefits only. All services must be medically necessary and appropriate, as determined by Highmark Blue Cross Blue Shield, for benefits to apply.
For questions concerning your benefits, please contact The Reschini Group at 1-800-442-8047.