

Freedom Area School District (Teachers, Administration, Support Staff)

Overview of Current PPOBlue Qualified High Deductible Health Plan

Non-Grandfathered

BENEFIT	PPOBlue Qualified High Deductible Health Plan Group Numbers - 17108-00 (Active) & -70 (Inactive)	
	In-Network Care ¹	Out-of-Network Care ^{1,2}
Policy Provisions		
Benefit Period	January 1 - December 31	
Benefit Period Deductible ³ (Employee Only Plan / Family Plan)	\$1,600 / \$3,200 Applies to Medical and Prescription Drug Benefits	
Co-Insurance (The Plan Pays:)	100% after deductible	80% after deductible
Annual Out-of-Pocket Maximum ⁴ (Employee Only Plan / Family Plan)	Not Applicable <i>Does not apply when the in-network co-insurance is 100% after deductible</i>	\$1,500 / \$3,000 ⁵ (not including deductibles) (not including balance billing)
Total Maximum Out-of-Pocket (Employee Only Plan / Family Plan) ⁶ (Includes medical and prescription drug deductible, coinsurance, & copays)	\$6,350 / \$12,700	Not Applicable
Lifetime Maximum Per Person	Unlimited	
Dependent Eligibility	Dependents to age 26	
Precertification Requirements	Yes (provider responsibility)	Yes ⁷
Preventive Care Services		
Routine Physical Exams (adult & pediatric)	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including PAP Test	100% (deductible does not apply)	80% (deductible does not apply)
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Childhood Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms - Routine	100% (deductible does not apply)	80% after deductible
Colorectal Cancer Screening - Routine	100% (deductible does not apply)	80% after deductible
Hospital / Physician Services		
Physician Office Visits	100% after deductible	80% after deductible
Specialist Office Visits	100% after deductible	80% after deductible
Maternity Care (facility & professional)	100% after deductible	80% after deductible
Inpatient Hospital Services	100% after deductible	80% after deductible
Outpatient Hospital Services	100% after deductible	80% after deductible
Medical/Surgical Services (except office visits)	100% after deductible	80% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT Scan, PET Scan, etc)	100% after deductible	80% after deductible
Basic Diagnostic Services (Standard Imaging, Diagnostic Medical, Lab/Pathology, Allergy Testing)	100% after deductible	80% after deductible
Mammograms - Medically Necessary	100% after deductible	80% after deductible
Colorectal Cancer Screening - Medically Necessary	100% after deductible	80% after deductible
Allergy Extracts	100% after deductible	80% after deductible
Transplant Services	100% after deductible	80% after deductible
Emergency Services		
Emergency Room Services ⁸	\$100 copayment per visit after deductible	
Ambulance	100% after deductible	80% after deductible
Therapy Services		
Spinal Manipulation Services	100% after deductible	80% after deductible
Physical Therapy Services	100% after deductible	80% after deductible
Speech & Occupational Therapy Services	100% after deductible	80% after deductible
Cardiac Rehabilitation, Chemotherapy, & Dialysis Treatment	100% after deductible	80% after deductible
Infusion, Radiation, & Respiratory Therapy Services	100% after deductible	80% after deductible

Freedom Area School District (Teachers, Administration, Support Staff)

Overview of Current PPOBlue Qualified High Deductible Health Plan

Non-Grandfathered

BENEFIT	PPOBlue Qualified High Deductible Health Plan Group Numbers - 17108-00 (Active) & -70 (Inactive)	
	In-Network Care ¹	Out-of-Network Care ^{1,2}
Behavioral Health Services		
Mental Health - Inpatient	100% after deductible	80% after deductible
Mental Health - Outpatient	100% after deductible	80% after deductible
Substance Abuse - Inpatient Detoxification	100% after deductible	80% after deductible
Substance Abuse - Inpatient Rehabilitation	100% after deductible	80% after deductible
Substance Abuse - Outpatient Rehabilitation	100% after deductible	80% after deductible
Other Services		
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diabetes Treatment	100% after deductible	80% after deductible
Durable Medical Equipment	100% after deductible	80% after deductible
Enteral Formulae	100% after deductible	80% after deductible
Home Infusion Therapy	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
Hospice Care	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment ⁹	100% after deductible	80% after deductible
Orthotics	100% after deductible	80% after deductible
Pediatric Extended Care Services	100% after deductible	80% after deductible
	<i>Combined Limit: 100 days per benefit period</i>	
Private Duty Nursing	100% after deductible	80% after deductible
Prosthetics	100% after deductible	80% after deductible
Skilled Nursing Facility	100% after deductible	80% after deductible
Prescription Drugs		
Prescription Drug Deductible	Works In Conjunction with Medical Deductible	
Prescription Drug (retail)	100% after deductible ¹⁰ Up to a 31 day supply National Pharmacy Network Open Formulary	
Prescription Drug (mail order)	100% after deductible ¹⁰ Up to a 90 day supply Open Formulary	

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 qualifies as a hospital department or a satellite building of a hospital.

² Precertification may be required for services rendered by out-of-network providers.

³ Deductible levels are determined by the IRS and are subject to change.

⁴ The out-of-pocket limit refers to the specified dollar amount of coinsurance incurred for covered services and covered medications in a benefit period. When the specified dollar amount is attained, your program begins to pay 100% of all covered expenses. In-network expenses are paid at 100% after satisfying the deductible; with 100% coverage there is no applicable coinsurance incurred; therefore, the out-of-pocket limit is not applicable.

⁵ 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.

⁶ The in-network total maximum out-of-pocket as mandated by the federal government must include medical and prescription drug deductible, coinsurance, & copays. If you are enrolled as an individual, the deductible, and Total Maximum Out-of-Pocket for the "Employee Only" plan apply. If you are enrolled in a "Family" plan, the entire family deductible and Total Maximum Out-of-Pocket apply.

⁷ 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.

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 At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible.

NOTE: This grid is only provided as a brief overview of benefits. 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.