Highmark Performance Flex Blue PPO

Bricklayers and Allied Craft Workers Welfare Fund of Western PA

Performance Flex Blue PPO – Base Plan A – Group numbers 107141-00,01,70

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out-of-pocket. 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	Network		Out-of-Network
	Enhanced Value	Standard Value	
General Provisions			
Benefit Period(1)	Calendar year		
Deductible (per benefit period) (All in-network services are credited to both the standard and the enhanced deductibles.) Individual Family	 $500 $1,000	 $1,500 $3,000	 $6,750 $11,250
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible	50% after deductible
Out-of-Pocket Limit (Includes deductible and coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period.) Individual Family	 $1,250 $2,250	 $3,750 $6,750	 $10,000 $20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug and other qualified medical expenses, Network only) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $10,150 $20,300		 Not applicable Not applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	100% after $20 copayment	100% after $40 copayment	50% after deductible
Primary Care Provider Office Visits	100% after $20 copayment	100% after $40 copayment	50% after deductible
Specialist Office & Virtual Visits	100% after $40 copayment	100% after $80 copayment	50% after deductible
Urgent Care Center Visits	100% after $40 copayment	100% after $80 copayment	50% after deductible
Telemedicine (5)	100% after $15 copayment		Not covered
Preventive Care(2)			
Routine Adult			
Adult immunizations	100% (deductible does not apply)		50% after deductible
Colorectal cancer screening	100% (deductible does not apply)		50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)		50% after deductible
Physical exams	100% (deductible does not apply)		50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)		50% (deductible does not apply)
Routine Pediatric			
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Pediatric immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Physical exams	100% (deductible does not apply)		50% after deductible
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Inpatient	90% after deductible	70% after deductible	50% after deductible
Hospital Outpatient	90% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services. Includes dependent daughter.)	90% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/**Surgical Expenses**	90% after deductible	70% after deductible	50% after deductible

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Emergency Services			
Emergency Room Services	100% after $125 copayment (waived if admitted)		
Ambulance (7)	90% after enhanced deductible		
Ambulance – Non-Emergency	90% after enhanced deductible		
Therapy, Rehabilitative and Habilitative Services			
Physical Medicine (Rehabilitative and Habilitative)	100% after $15 copayment	100% after $30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Respiratory Therapy	90% after deductible	70% after deductible	50% after deductible
Speech & Occupational Therapy (Rehabilitative and Habilitative)	100% after $15 copayment	100% after $30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Spinal Manipulations	100% after $15 copayment	100% after $30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible	50% after deductible
Mental Health/Substance Abuse			
Inpatient	90% after enhanced deductible		50% after deductible
Inpatient Detoxification/Rehabilitation	90% after enhanced deductible		50% after deductible
Outpatient	100% after $15 copayment		50% after deductible
Other Services			
Allergy Extracts and Injections	90% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible	50% after deductible
Diagnostic Services			
Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	70% after deductible	50% after deductible
Home Health Care	90% after deductible	70% after deductible	50% after deductible
Hospice	90% after deductible	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment(3)	90% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	90% after deductible	70% after deductible	50% after deductible
	Limit: 240 hours/benefit period		
Skilled Nursing Facility Care	90% after deductible	70% after deductible	50% after deductible
	Limit: 100 days per benefit period		
Transplant Services	90% after deductible	70% after deductible	50% after deductible
Precertification Requirements(4)	YES		
Prescription Drugs			
Prescription Drug Deductible Individual Family	None None		
Prescription Drug Program(6) *Defined by the **National Pharmacy Network** - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.*	**Retail Drugs 31-day Supply (Mandatory Generic)** $10 generic copayment $55 brand copayment - formulary $80 brand copayment – non-formulary Specialty Drugs – Limited to a 30 day supply **Maintenance Drugs through Mail Order 90-day Supply (Mandatory Generic)** $20 generic copayment $110 brand copayment - formulary $160 brand copayment – non-formulary Specialty Drugs – Limited to a 30 day supply		
Incentive Choice Home Program	After the 2nd fill of a maintenance medication at a retail pharmacy, a $5 penalty applies if not filled through the home delivery.		

(1) Your group's benefit period is based on a Calendar Year. The Calendar Year is from January 1-December 31.
(2) Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). 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) 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 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) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health/Substance abuse benefit
(6) 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

**The terms "enhanced value" and "standard value" are not descriptors of the provider's ability. This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.*

clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, 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.

(7) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits