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HIGHMARK. | PPO Blue

Messiah University PPO Blue $250 Student Health Insurance Plan {Gold Tier} (84.36% Actuarial Tier)

Undergraduate Students: $2,067.60 (8/1/2024 – 7/31/2025)
Graduate Students: $3,101.52 (8/1/2024 – 7/31/2025)

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.

	Network	Out-of-Network
General Provisions		
Benefit Period[1]	Contract Year	
Deductible (per benefit period) Individual Family	 $250 $500	 $600 $1,200
Plan Payment Level – based on the plan allowance	100%	60%
Out-of-Pocket Limit Individual Family	 None None	 $10,000 $20,000
Total Maximum Out-of-Pocket Individual Family	 $7,500 $13,700	 None None
Outpatient Medical Care Visits and Telemedicine Services		
Retail Clinic Visits & Virtual Visits	80% after $25 copayment	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits[2,3]	80% after $25 copayment	80% after deductible
Specialist Office Visits & Virtual Visits[2]	80% after $25 copayment	80% after deductible
Virtual Visit Provider Originating Site Fee	100% (deductible does not apply)	60% (deductible does not apply)
Urgent Care Center Visits	80% after $50 copayment	80% after $50 copayment
Telemedicine Services[4]	80% after $25 copayment	Not Covered
Preventive Care Services[5]		
Routine Physical exams (Adult & Pediatric)	100% (deductible does not apply)	Not Covered
Adult immunizations	100% (deductible does not apply)	60% after deductible
Breast Cancer Screenings (includes mammograms and BRCA-Related Genetic Counseling and Genetic Testing)	100% (deductible does not apply)	60% after deductible
Colorectal cancer screenings	100% (deductible does not apply)	60% after deductible
Diabetes Prevention Program	100% (deductible does not apply)	Not Covered
Pediatric immunizations	100% (deductible does not apply)	60% after deductible
Routine Gynecological Examinations and Papanicolaou Smear	100% (deductible does not apply)	60% after deductible
Routine Screening tests and procedures	100% (deductible does not apply)	60% after deductible
Tobacco Use Counseling and Interventions	100% (deductible does not apply)	60% after deductible
Vision Care Services		
Pediatric Vision Care[6]	100% (deductible does not apply)	Not Covered
Pediatric Dental Services[6]		
Consultations, Routine Exams, X-rays, Cleanings, Fluoride Treatments, Palliative Treatment (emergency), Sealants and Space Maintainers	100%	Not Covered
Other Pediatric Dental Services	50%	Not Covered
Emergency Room and Ambulance Services		
Emergency Room Services	80% after $150 copayment	
Ambulance - Emergency	80% after network deductible	
Ambulance – Non-emergency[7]	80% after deductible	60% after deductible
Hospital and Medical/Surgical Services		
Hospital Inpatient	80% after deductible	60% after deductible
Hospital Outpatient	80% after deductible	60% after deductible
Maternity Services[9]	80% after deductible	60% after deductible
Inpatient Medical Care Services	80% after deductible	60% after deductible
Surgical Services	80% after deductible	60% after deductible
Habilitative and Rehabilitative Services		
Cardiac Rehabilitation	80% after deductible	60% after deductible
	Cardiac Rehabilitation does not include services provided for habilitative purposes.	
Occupational Therapy	80% after deductible	60% after deductible
	Limits: unlimited habilitative and rehabilitative Visits per Benefit Period. Limits do not apply to services prescribed for the treatment of Mental Health or Substance Abuse.	
Physical Medicine	80% after deductible	60% after deductible

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	Network	Out-of-Network
	Limits: unlimited habilitative and rehabilitative Visits per Benefit Period. Limits do not apply to services prescribed for the treatment of Mental Health or Substance Abuse.	
Speech Therapy	80% after deductible	60% after deductible
	Limits: unlimited habilitative and rehabilitative Visits per Benefit Period. Limits do not apply to services prescribed for the treatment of Mental Health or Substance Abuse.	
Mental Health Care Services and Substance Abuse Services		
Inpatient Care	80% after deductible	60% after deductible
Outpatient Care	80% after $25 copayment	80% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	60% after deductible
Anesthesia for Non-Covered Dental Procedures (Limited) and Dental Services Related to Accidental Injury	80% after deductible	80% after deductible
Artificial Insemination	100% after deductible	60% after deductible
Autism Spectrum Disorders Applied Behavioral Analysis[8]	100% after deductible	60% after deductible
Diabetes Treatment		
Equipment and Supplies	100% after deductible	60% after deductible
Diabetes Education Program	100% after deductible	60% after deductible
Diabetes Care Management Program (Digitally Monitored)	100% (deductible does not apply); continuous glucose monitor sprints are limited to three (3) per benefit period	Not Covered
Diagnostic Services *Advanced Imaging* (CT, CTA, MRI, MRA, PET scan, PTE/CT scan, etc.)	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances	80% after deductible	60% after deductible
Enteral Foods	100% (deductible does not apply)	50% (deductible does not apply)
Home Health Care and Hospice Care Services	80% after deductible	60% after deductible
	Respite Care is limited to 7 days every 30-day period	
Home Infusion and Suite Infusion Therapy	100% after deductible	60% after deductible
Skilled Nursing Facility Services	80% after deductible	60% after deductible
	Limit: 360 Days per Benefit Period	
Spinal Manipulations	80% after deductible	60% after deductible
	Limit: 360 Visits per Benefit Period	
Therapy Services (Chemotherapy, Dialysis, Infusion Therapy, Pulmonary Therapy, Radiation Therapy, Respiratory Therapy)	80% after deductible	60% after deductible
Transplant Services	100% after deductible	60% after deductible
Coverage Outside of the United States	Coverage for medical services provided outside of the United States is the same as coverage for medical services provided inside the United States. In most cases you will need to pay up front and submit a claim for reimbursement. To learn more, visit www.bcbsglobalcore.com. Prescription drugs are not covered when dispensed outside the United States	
Travel Assistance Services	Your plan includes a package of Travel Assistance Services to help you when you are traveling outside of your home country or more than 100 miles from your home. This package includes emergency medical evacuation, medical repatriation, return of mortal remains and many other benefits. The maximum benefit per trip is $500,000. See your Travel Assistance Program Brochure for more details.	

Note: Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services you receive during a benefit period will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether you have satisfied your deductible.

1 Your group's benefit period is based on a contract year. The contract year is a consecutive 12-month period beginning on August 1st.

2 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 hospital, facility provider, ancillary provider, retail clinic or urgent care center. The virtual visit is subject to availability within your service area.

3 A physician whose practice is limited to family practice, general practice, internal medicine or pediatrics.

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 on the Highmark Preventive Schedule and the Women's Health Preventive Schedule. Gender, age and frequency limits may apply.

6 Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.

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

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[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 covered according to the benefit category (e.g. speech therapy, diagnostic services). Services for the treatment of Autism Spectrum Disorders do not reduce visit/day limits.

Prescription Drug Benefits	Retail Pharmacy Up to 31-day supply[1,2]	Maintenance Prescription Drugs through Mail Order Up to 90-day supply
Pharmacy Network	National	Express Scripts Pharmacy
Formulary[3]	Your plan uses the Comprehensive Formulary with an Incentive Benefit Design[4]	
Mandatory Generic Provision	SensibleRx Choice[5]	
The following cost-sharing provisions do NOT apply to self-administered chemotherapy medications, including oral chemotherapy medications.		
Prescription Drug Deductible **Individual** **Family**	None None	
Generic Prescription Drug	$25 copay	$75 copay
Brand Formulary Prescription Drug	$60 copay	$180 copay
Brand Non-Formulary Prescription Drug	$75 copay	$225 copay
Preventive Medications		
Preventive Covered Drugs and Immunizations[6]	Deductibles, coinsurance and/or copayments do not apply	

[9] The maternity home health care visit for network care is not subject to the program copayment, coinsurance or deductible amounts, if applicable. See Maternity Home Health Care Visit in the Maternity Services section of the Description of Benefits.

1. Certain retail participating pharmacy providers may have agreed to make covered medications available at the same cost-sharing and quantity limits as the mail order coverage. You may contact Highmark at the toll-free number or the Web site appearing on the back of your ID card for a listing of those pharmacies who have agreed to do so.

2. The quantity level limit for your initial prescription order may be reduced, depending on the particular medication, to a quantity level necessary to establish that you can tolerate the medication. The cost-sharing provisions indicated above will be adjusted accordingly for the initial prescription order based upon the initial quantity dispensed. If you are able to tolerate the medication, the remainder of the available days supply for the initial prescription order will be filled and you will be responsible for the balance of the applicable cost-sharing amount indicated above.

3. The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and by their cost-sharing requirements.

4. This formulary lists the specific prescription drugs your program covers. To request a prescription drug that is not on this formulary, your provider must complete the Prescription Drug Medication Request Form and return it to the Clinical Services Department for clinical review. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. This formulary covers all FDA-approved generic and brand-name drugs.

5. Under the SensibleRx Choice mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment and/or coinsurance plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed. Under the SensibleRx Complete mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment and/or coinsurance plus the difference in cost between the brand and generic drugs.

6. This includes prescriptions, over-the-counter drugs and immunizations that are set forth within the predefined schedule and that are prescribed for preventive purposes. Please refer to the Description of Benefits - Prescription Drug Program section for more information.