

## PPO Blue Summary of Benefits

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.

Group Numbers: 016452-00, 01, 02, 70, 71, 72

Benefit	In Network	Out of Network
<b>General Provisions</b>		
Effective Date	March 1, 2025	
Benefit Period (1)	Contract Year	
Deductible (per benefit period)		
Individual	None	\$1,000
Family	None	\$2,000
Plan Pays – payment based on the plan allowance	100%	80% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	None	\$2,500
Family	None	\$5,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	None	None
Family	None	None
<b>Office/Clinic/Urgent Care Visits</b>		
Retail Clinic Visits & Virtual Visits	100% after \$10 copay	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after \$10 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after \$10 copay	80% after deductible
Virtual Visit Provider Originating Site Fee	100%	80% after deductible
Urgent Care Center Visits	100% after \$10 copay	80% after deductible
	Copayment, if any, does not apply to Urgent Care Center Visits prescribed for the treatment of Mental Health or Substance Abuse	
Telemedicine Services (3)	100% after \$5 copay	Not Covered
<b>Preventive Care (4)</b>		
<b>Routine Adult</b>		
Physical Exams	100% after \$10 copay	Not Covered
Adult Immunizations	100%	80% after deductible
Routine Gynecological Exam	100% after \$10 copay	80% (deductible does not apply)
Routine Pap Smear	100%	80% (deductible does not apply)
Breast Cancer Screenings (annual routine and supplemental)	100%	80% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100%	80% after deductible
Colorectal Cancer Screening	100%	80% after deductible
Diagnostic Services and Procedures	100%	80% after deductible
<b>Routine Pediatric</b>		
Physical Exams	100% after \$10 copay	Not Covered
Pediatric Immunizations	100%	80% (deductible does not apply)
Diagnostic Services and Procedures	100%	80% after deductible
<b>Emergency Services</b>		
Emergency Room Services (5)	100% after \$35 copay (waived if admitted)	
Ambulance - Emergency (6)	100% (deductible does not apply)	
Ambulance - Non-Emergency (6)	100%	80% after deductible
<b>Hospital and Medical / Surgical Expenses (including maternity) (5)</b>		
Hospital Inpatient	100%	80% after deductible
Hospital Outpatient	100%	80% after deductible
Outpatient Surgery (facility)	100%	80% after deductible
Surgical Services (professional)	100%	80% after deductible
Maternity (non-preventive professional services) including dependent daughter	100%	80% after deductible

Benefit	In Network	Out of Network
Medical Care (including inpatient visits and consultations)	100%	80% after deductible
<b>Therapy and Rehabilitation Services</b>		
Physical Medicine	100% after \$10 copay	80% after deductible
	Limit: 20 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Speech Therapy	100% after \$10 copay	80% after deductible
	Limit: 20 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Occupational Therapy	100% after \$10 copay	80% after deductible
	Limit: 20 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Respiratory Therapy	100%	100% after in-network deductible
Spinal Manipulations	100% after \$10 copay	80% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
<b>Mental Health / Substance Abuse</b>		
Inpatient Mental Health Services	100%	80% after deductible
Inpatient Detoxification / Rehabilitation	100%	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100%	80% after deductible
Outpatient Substance Abuse Services	100%	80% after deductible
<b>Other Services</b>		
Allergy Extracts and Injections	100%	80% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	100%	80% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	100%	80% after deductible
<b>Diabetes Treatment</b>		
Equipment and Supplies	100%	80% after deductible
Diabetes Education Program	100%	80% after deductible
<b>Diagnostic Services</b>	Copayments, if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse	
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
Mammograms, Medically Necessary	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible
Home Health Care	100%	80% after deductible
Hospice	100%	80% after deductible
Infertility Counseling, Testing and Treatment (8)	100%	80% after deductible
Private Duty Nursing	100%	100% after in-network deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100%	80% after deductible ; benefit maximum of 100 days/benefit period
Transplant Services	100%	80% after deductible
Precertification/Authorization Requirements (9)	Yes	
<b>Prescription Drugs</b>		
Prescription Drug Deductible Individual Family	None None	
Prescription Drug Program (10) SensibleRx Choice 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	<b>Retail Drugs (31-day Supply)</b> \$10 generic copay \$20 formulary brand copay \$35 non-formulary brand copay <b>Maintenance Drugs through Mail Order (90-day Supply)</b> \$20 generic copay \$40 formulary brand copay \$70 non-formulary brand copay	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.

(2) Not Applicable

(3) 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).

(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).

(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.

(6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.

(7) 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.

(8) 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.

(9) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.

(10) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved 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 in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under SensibleRx Choice, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed. Your plan requires that you use Accredo specialty pharmacy for select specialty medications. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment.

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield or Highmark Choice Company, which are independent licensees of the Blue Cross Blue Shield Association.

Signature:	Name:
Title:	Date: