PPO Sharing $250

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.

Benefit	Network	Out-of-Network
General Provisions		
Effective Date	January 1, 2022	
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $250 $500	 $1,000 $2,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 None None
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 Family	 $8,700 $17,400	 $8,700 $17,400
Office/Clinic/Urgent Care Visits		
Retail Clinic Virtual Visits	100% after $10 copay	80% after deductible
Retail Clinic Visits	100% after $20 copay	80% after deductible
Primary Care Provider Virtual Visits	100% after $10 copay	80% after deductible
Primary Care Provider Office Visits	100% after $20 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after $30 copay	80% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $50 copay	80% after deductible
Telemedicine Services(3)	100% after $20 copay	Not Covered
Preventive Care(4)		
Routine Adult Physical exams	 100% (deductible does not apply)	 80% after deductible
Adult immunizations	100% (deductible does not apply)	80% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, annual routine	100% (deductible does not apply)	80% after deductible
Mammograms, medically necessary	100% after deductible	80% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric Physical exams	 100% (deductible does not apply)	 80% after deductible
Pediatric immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services	100% after $100 copay (waived if admitted)	
Ambulance – Emergency	100% deductible waived	
Ambulance – Non-Emergency	100% after deductible	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses, including abortions	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $30 copay	80% after deductible
	Limit: Unlimited visits/benefit period	
Respiratory Therapy	100% after $30 copay	80% after deductible
	Limit: 30 visits/benefit period	
Speech Therapy	100% after $30 copay	80% after deductible
	Limit: 30 visits/benefit period	

Benefit	Network	Out-of-Network
Therapy and Rehabilitation Services (cont.)		
Occupational Therapy	100% after $30 copay	80% after deductible
	Limit: 30 visits/benefit period	
Spinal Manipulations	100% after $30 copay	80% after deductible
	Limit: Unlimited visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health/Substance Abuse		
Inpatient Mental Health Services	100% after deductible	80% after deductible
Inpatient Detoxification	100% after deductible	80% after deductible
Acute Inpatient Rehabilitation	100% after deductible	50% after deductible
	60 days/benefit period	
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $30 copay	80% after deductible
Outpatient Substance Abuse Services	100% after deductible	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder(5)	100% after deductible	80% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, 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
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	50% after deductible
	Limit: 90 visits/benefit period	
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment(6)	100% after deductible	80% after deductible
Private Duty Nursing	Not Covered	Not Covered
Skilled Nursing Facility Care	100% after deductible	50% after deductible
	Limit: 100 days/benefit period	
Transplant Services	100% after deductible	80% after deductible
Precertification/Authorization Requirements(7)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual	$25 per member	
Prescription Drug Program(8) Soft Mandatory Generic 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. **Select Specialty Drugs are limited to 31-day Supply**	**Retail Drugs (30-day Supply)** Member pays 25% generic coinsurance Member pays 25% formulary brand coinsurance Member pays 45% non-formulary brand coinsurance **Specialty Drugs (Retail/Mail Order)** 25% for specialty drugs with $150 maximum per prescription **Maintenance Drugs through Mail Order or Smart90-CVS Pharmacy (90-day Supply)** $25 generic copay $75 formulary brand copay $125 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) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) 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 benefit.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Coverage for eligible members to age 21. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.

(6) 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.

(7) 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.

(8) 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 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 the soft mandatory generic provision, 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 Alliance Rx Walgreens Prime specialty pharmacy to obtain select specialty medications. To obtain medications for hemophilia, you must use a specific pharmacy, please contact member services for more details. A member can go to any pharmacy in the National network for the first 2 (31 day) fills of a "maintenance" medication. For their 3rd fill forward, they must either use a "Smart90" Pharmacy (CVS) to get a 90 day supply, or Mail Order. If they do not, the member will be responsible for 100% of the medication cost.