Summary of Benefits

This Summary of Benefits is a brief description of covered services.

PLAN YEAR IV  Deductible (per plan year) Includedual Family  If you and your spouse voluntarily If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network deductible in the spouse spouse plants and the deductible  If you and your spouse voluntarily requirements, the in-network deductible is waived.  If you and your spouse voluntarily requirements, the in-network and the reductible  If you and your spouse voluntarily requirements, the in-network and the reductible  If you and your spouse voluntarily requirements, the in-network and the reductible  If you an		Performance E	Blue PPO	PPO Blu	ıe
PLAN YEAR (*)  CALENDAR YEAR  CALENDAR TEAR  CALENDAR TEAR  CALENDAR TEAR  S800 \$1,600 \$3,200 \$2,000 \$3,400	Benefit	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (per plan year) Individual Family  If you and your spouse voluntarily complete for well-ness requirements, the in-network deductible is waived.  If you and your spouse voluntarily complete for well-ness in-dividual deductible will be reduced to \$1,200 and the family deductible is waived.  If you and your spouse voluntarily complete for well-ness in-dividual deductible will be reduced to \$1,200 and the family deductible is waived.  Out-of-Pocket Limit (Choce met, plan pays 100% consumers for the rest of the plan year)  Family  None  \$6,800  None		Gener	ral Provisions		
If you and your spouse rolluntarily complete the wellness requirements, the in-network deductible is walved.    If you and your spouse rolluntarily complete the wellness requirements, the in-network deductible is walved.   If you and your spouse rolluntarily complete the wellness requirements, the in-network deductible is walved.   If you and your spouse rolluntarily complete the wellness requirements, the in-network deductible is search of the part of the wellness requirements, the in-network deductible is search of the reductible is 52-20.00   S. 52-20.0	PLAN YEAR (1)		CALENDA	R YEAR	
Family   Si,000   S3.200   \$4.000   \$					
If you and your spouse voluntarily complete the wellness requirements. the in-network deductible is waived.  Plan Pays – payment based on the plan allowance of the plan between the plan plan allowance of the plan between the plan plan allowance of the plan plan allowance of the plan between the plan plan allowance of the plan plan allowance of the plan between the plan plan allowance of the pla					\$2,400 \$4,800
If you and your spouse voluntarily complete the wellness requirements the in-retwork seducible is wiseless expenses, the in-retwork seducible is wiseless and seducible is seducible in the seducible in the seducible is seducible in the seducible in the seducible is seducible in the seducible is seducible in the seducible in the seducible in the seducible is seducible in the seducible is seducible in the seducible in the seducible in the seducible is seducible in the s	1 anily	ψ1,000	ψ0,200	. ,	ψ+,000
Plan Pays – payment based on the plan allowance 100% after deductible is walved. deductible will be reduced to \$2,400. document of the plan pays 100% consurance for the rest of the plan pays 100% consurance for the rest of the plan pays 100% consurance for the rest of the plan pays 100% consurance for the rest of the plan pays 100% none \$4,800 None \$4,		If you and your spouse voluntarily			
Plan Pays – payment based on the plan allowance					
Plan Pays – payment based on the plan   100% after deductible   80% after deductible   100% after deductible   20% after deductible   100% after deductible   20% after deductible					
Plan Pays – payment based on the pian allowance   100% after deductible   80% after deductible   100% after deductible   80% after deductible   100% after deductible   80% after ded				deductible will be reduced	
DUS- after deductible   DUS- after store	Dien Deug normant begand an the nigh			to \$2,400.	
Out-of-Pocket Limit (Once met, plan pays 100% consumers for the trest of the plan year)   None   \$4,800   No	• • • • • • • • • • • • • • • • • • • •	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Individual Family  None S9,800					
Total Maximum Out-of-Pocket (includes deductible, coinsurance, copays, prescription drug oset sharing and other qualified medical expenses, Network only) iz Once met, the plan pays 100% of covered services for the rest of the benefit period.  ### Applicable   S8.150					
Total Maximum Out-of-Pocket (includes deductible, consideration, consystement) and other qualified medical expenses, Network only) and other met, the plan pays 100% of covered services for the rest of the benefit period.  **Retall Clinic Visits & Virtual Visits  **Retall Clinic Visits & Virtual Visits  **Retall Clinic Visits & Virtual Visits  **Primary Care Provider Office Visits & Virtual Visits  **Provider Office Visits & Virtual Visits  **Pr					\$4,800 \$9,600
deductible, coinsurance, copays, prescription drug osst sharing and other qualified medical expenses, Network only) in Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual \$3,150 Not Applicable \$1,500 Not Applicable \$1,50	· · · · · · · · · · · · · · · · · · ·	None	φ9,000	INOTIE	φ9,000
expenses, Network only) (a) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family Pays 100% of covered services for the rest of the benefit period. Individual St 51500 Not Applicable Not Applicable Not Applicable St 5300 Not Applicable St 5300 Not Applicable St 54500 Not Applicable Not Applicable St 54500 Not Applic	deductible, coinsurance, copays, prescription				
pays 10% of covered services for the rest of the benefit period. Individual   \$8,150   Not Applicable   \$8,150   Not Applicable   \$16,300   Not Applicable   \$16,300   Not Applicable   \$16,300   Not Applicable   \$16,300   Not Applicable   \$100% after \$15 copayment   \$150% after \$150 copayment   \$					
benefit period. Individual Family S16,300 Not Applicable S16,300 Not					
Since   Sin	benefit period.				
Office/Clinic Visits & Virtual Visits   100% after \$15 copayment   80% after deductible   100% after \$15 copayment   80% after store of the Visits   100% after \$15 copayment   80% after deductible   100% after \$15 copayment   80% after store of the Visits   100% after \$15 copayment   80% after deductible   100% after \$30 copayment   80% after store of the Visits   100% after \$30 copayment   80% after deductible   100% after \$30 copayment   80% after   80% af					Not Applicable Not Applicable
Retail Clinic Visits & Virtual Visits   100% after \$15 copayment   80% after deductible   100% after \$15 copayment   80% after Primary Care Provider Office Visits & Virtual Visits   100% after \$15 copayment   80% after deductible   100% after \$15 copayment   80% after Specialist Office & Virtual Visits   100% after \$15 copayment   80% after deductible   100% after \$30 copayment   80% after Virtual Visit Originating Site Fee   100% after deductible   80% after deductible   100% after \$30 copayment   80% after Urgent Care Center Visits   100% after \$15 copayment   80% after deductible   100% after \$15 copayment   80% after General Virtual Visits Originating Site Fee   100% after \$15 copayment   80% after deductible   100% after \$15 copayment   80% after General Visits   100% (deductible does not apphy)   Not Covered   100% (deductible does not apphy   Not Covered   100% (deductible does not apphy   Not Covered   100% (deductible does not apphy   80% after deductible   100% after deductible   80% after ded	1 diffiny	. ,		\$10,300	Not Applicable
Primary Care Provider Office Visits & Virtual Visits  100% after \$15 copayment  100% after \$30 copayment  100% after \$40 c	Rotail Clinic Visite & Virtual Visite		•	100% after \$15 copayment	80% after deductible
Visits   100% after \$10 copayment   80% after deductible   100% after \$30 copayment   80% after Virtual Visit Originating Site Fee   100% after \$30 copayment   80% after deductible   100% after \$30 copayment   80% after Urgent Care Center Visits   100% after \$15 copayment   80% after deductible   100% (deductible does not apply)   100% (deductible d				' '	
Virtual Visit Originating Site Fee 100% after deductible 80% after deductible 100% after deductible 100% after deductible 100% after st 5 copayment 80% after deductible 100% (deductible does not apply) Not Covere 100% (deductible does not apply) Not Covered 100% (deductible does not apply) 80% after deductible 100% (deductible does not apply) 100% (deductible does	Visits	. ,			80% after deductible
Urgent Care Center Visits 100% after \$15 copayment, if any does not apply to Urgent Care visits prescribed for the treatment of Mental Health or Substar Telemedicine (a) 100% (deductible does not apply) Not Covered 100% (deductible does not apply) 80% after deductible 100% after deductible 100% after deductible 100%					80% after deductible
Copayment, if any does not apply) to Urgent Care visits prescribed for the treatment of Mental Health or Substar Telemedicine (a) 100% (deductible does not apply) Not Covered 100% (deductible does not apply) 80% after deductible 100% after deductible 100% after deductible 100% after deducti					80% after deductible
Telemedicine (3) 100% (deductible does not apply) Not Covered 100% (deductible does not apply)  Routine Adult Physical exams 100% (deductible does not apply) 80% after deductible 100% after stole to apply 90% after deductible 100% after deductibl	Urgent Care Center Visits	· ' '			80% after deductible
Routine Adult Physical exams Adult immunizations 100% (deductible does not apply) 80% after deductible 100% after st00 copayment (waived if admitted) 100% after st00 copayment (waived if admitted) 100% after st00 copayment (waived if admitted) 100% after deductible 100% after deductible 100% after deductible 80% after deductible 100% after deductible 100% after deductible 100% after deductible 100% after deductible 80% after deductible 100% after deductible 100% after deductible 80% after deductible 100% after deductible 100% after deductible 80% after deductible 100% after deductible 100% after deductible 80% after					
Routine Adult   Physical exams	Telemedicine (3)			100% (deductible does not apply)	Not Covered
Physical exams  Adult immunizations  100% (deductible does not apply)  80% after deductible 100% (deductible does not apply) 80% after deductible 100% (deductible does not apply) 80% after deductible 100% (deductible does not apply) 80% after deductible 100% (deductible does not apply) 80% after deductible 100% (deductible does not apply) 80% after deductible 100% (deductible does not apply) 80% (deductible does not apply) 80% after deductible 100% after deductible 100% after deductible 100% after deductible 100% after deductibl	Davidina Adult	Prevent	ive Care (4)	T .	
Adult immunizations 100% (deductible does not apply) 80% after deductible 100% (deductible does not apply) 80% after deductible 2006 (deductible does not apply) 80% after deductible 30% (deductible does not apply) 80% after deductible 40% (deductible does not apply) 80% after deductible 40% (deductible does not apply) 80% after deductible 80% (deductible does not apply) 80% after deductible 80% (deductible does not apply) 80% after deductible 80% after deductible 90% (deductible does not apply) 80% after		100% (deductible does not apply)	90% after deductible		000/ -#
Colorectal cancer screening 100% (deductible does not apply) 80% after deductible 100% (deductible does not apply) 80% after deductible does not apply) 100% (deductible does not apply) 100% (deducti		1000/ (daductible dage not apply)	•••••	• • • • • • • • • • • • • • • • • • • •	80% after deductible 80% after deductible
Routine gynecological exams, including a Pap Test 100% (deductible does not apply) 80% (deductible does not apply) 100% (deductible				100% (deductible does not apply)	
Pap Test 100% (deductible does not apply) does not apply) 100% (deductible does not apply) does not apply) 100% (deductible does not	Colorectal cancer screening	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Mammograms, annual routine and medically necessary: 100% (deductible does not apply) Diagnostic services and procedures 100% (deductible does not apply) Pediatric Physical exams 100% (deductible does not apply) Diagnostic services and procedures 100% (deductible does not apply) Pediatric immunizations 100% (deductible does not apply) Diagnostic services and procedures 100% (deductible does not apply) Diagnostic services and procedures 100% (deductible does not apply) Diagnostic services and procedures 100% (deductible does not apply) Diagnostic services and procedures 100% (deductible does not apply) Diagnostic services and procedures 100% (deductible does not apply) Diagnostic services and procedures 100% (deductible does not apply) Diagnostic services and procedures 100% (deductible does not apply) Diagnostic services and procedures 100% (deductible does not apply) Diagnostic services and procedures 100% (deductible does not apply) Diagnostic services and procedures 100% (deductible does not apply) Diagnostic services and procedures 100% (deductible does not apply) Diagnostic services and procedures 100% (deductible does not apply) Diagnostic services 100% after deductible		100% (deductible does not apply)		1000/ (doductible doce not cont.)	80% (deductible
Diagnostic services and procedures 100% (deductible does not apply) 80% after deductible 100% (deductible does not apply) 80% after deductible 100% (deductible does not apply) 80% after deductible 200% (deductible does not apply) 80% after does not apply) 80% after deductible 200% (deductible does not apply) 80% after deductible 200% after deduct		Pouting and Madically Negations	does not apply)	• • • • • • • • • • • • • • • • • • • •	does not apply)
Routine Pediatric Physical exams  100% (deductible does not apply) Pediatric immunizations  100% (deductible does not apply) Diagnostic services and procedures  100% (deductible does not apply) Poliagnostic services and procedures  100% (deductible does not apply) Poliagnostic services and procedures  100% (deductible does not apply) Poliagnostic services and procedures  100% (deductible does not apply) Poliagnostic services  Emergency Services  Emergency Services  Emergency Room Services  100% after \$100 copayment (waived if admitted) 100% after \$100 copayment (waived if admitted) 100% after \$100 copayment (waived if admitted) 100% after deductible 10			80% after deductible		80% after deductible
Routine Pediatric   Physical exams   100% (deductible does not apply)   80% after deductible   100% (deductible does not apply)   80% after deductible   100% (deductible does not apply)   80% after deductible does not apply)   100% (deductible does not apply)   80% after deductible does not apply)   100% (deductible does not apply)   80% after deductible   100% after \$100 copayment (waived if admitted)   100% after \$100 copayment (waived if admitted)   100% after \$100 copayment (waived if admitted)   100% after deductible   80% after deductible   100% after deductibl	Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Pediatric immunizations 100% (deductible does not apply) Diagnostic services and procedures 100% (deductible does not apply) Bo% after deductible 100% after \$100 copayment (waived if admitted) 100% after \$100 copayment (waived if admitted) 100% after \$100 copayment (waived if admitted) 100% after deductible 100	Routine Pediatric				
Diagnostic services and procedures 100% (deductible does not apply) 80% after deductible 100% after \$100 copayment (waived if admitted) 100% after deductible 100% after deductible 80% after deductible Professional: 100% after deductible Reductible Professional: 100% after deductible Reductible Professional: 100% after deductible Reductible	Physical exams	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Diagnostic services and procedures 100% (deductible does not apply) 80% after deductible 100% (deductible does not apply) 80% after deductible 50% after deductible 100% after \$100 copayment (waived if admitted) 100% after \$100 copayment (waived if a dmitted) 100% after deductible 100% after deductible 80% after deductible 100% after deductible 80% after deductible 100% after deductible 100% after deductible 80% after deductible 100% after deductible 100% after deductible Professional: 100% after deductible Professional: 100% after deductible Professional: 100% after deductible Professional: 100% after \$15 copayment 100% after deductible Professional: 100% after deductible 80% after deductible Professional: 100% after deductible Professional: 100% after deductible 80% after deductible Professional: 100% after \$15 copayment 100%	Pediatric immunizations	100% (deductible does not apply)		4000/ (daduatible dasa sat assis)	80% (deductible
Emergency Room Services  100% after \$100 copayment (waived if admitted)  100% after deductible  100% after	Diagnostic services and procedures	100% (deductible does not apply)	•••••••••••••••••••••••••••••••••••••••	***************************************	does not apply) 80% after deductible
Emergency Room Services  100% after \$100 copayment (waived if admitted)  100% after deductible  100% after	Diagnostic services and procedures	. , , , , , , , , , , , , , , , , , , ,		100% (deductible does not apply)	00 /0 drier deddelible
Ambulance – Emergency (5)  Ambulance – Non-Emergency (5)  100% after deductible	Emergency Room Services		•	100% after \$100 copayment	(waived if admitted)
Ambulance – Non-Emergency (5)  100% after deductible  Hospital and Medical/Surgical Expenses (including maternity)  Hospital Inpatient  100% after deductible  100% after deductible  80% after deductible  100% after deductible  80% after deductible  100% after deductible  80% after deductible  100% after deductible  80% after deductible  80% after deductible  Facility: 100% after deductible  Professional: 100% after deductible  Professional: 100% after s15 copayment  Medical Care (including inpatient visits and consultations)/Surgical Expenses  100% after deductible  80% after deductible  80% after deductible  80% after deductible  100% after deductible  100% after deductible  80% after deductible  100% after deductible  80% after deductible  80% after deductible  100% after deductible  80% after deductible  80% after deductible  80% after deductible					
Hospital and Medical/Surgical Expenses (including maternity)  Hospital Inpatient 100% after deductible 80% after deductible 80% after deductible 80% after deductible Professional: 100% after deductible Professional: 100% after \$15 copayment \$80% after deductible	<u> </u>				80% after deductible
Hospital Inpatient100% after deductible80% after deductible100% after deductible80% after deductibleHospital Outpatient100% after deductible80% after deductible100% after deductible80% after deductibleMaternity (non-preventive facility & professional services) including dependent daughterFacility: 100% after deductible Professional: 100% after \$15 copayment80% after deductible Professional: 100% after \$15 copaymentFacility: 100% after deductible Professional: 100% after \$15 copaymentMedical Care (including inpatient visits and consultations)/Surgical Expenses100% after deductible80% after deductible100% after deductible80% after	3.00	Hospital and Medical/Surgical	Expenses (including mate	ernity)	
Maternity (non-preventive facility & professional services) including dependent daughter       Facility: 100% after deductible Professional: 100% after \$15 copayment       80% after deductible       Facility: 100% after deductible Professional: 100% after \$15 copayment       80% after deductible       Facility: 100% after deductible Professional: 100% after \$15 copayment       80% after deductible       <	Hospital Inpatient			T * * * * * * * * * * * * * * * * * * *	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter       Facility: 100% after deductible Professional: 100% after \$15 copayment       80% after deductible       Facility: 100% after deductible Professional: 100% after \$15 copayment       80% after deductible       Facility: 100% after deductible Professional: 100% after \$15 copayment       80% after deductible       <	Hospital Outpatient	100% after deductible	80% after deductible		80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses  Professional: 100% after \$15 80% after deductible  Professional: 100% after \$15 copayment  Professional: 100% after \$15 copayment  100% after deductible  80% after deductible  100% after deductible  100% after deductible  Therapy and Rehabilitation Services				<u></u>	
Medical Care (including inpatient visits and consultations)/Surgical Expenses  100% after deductible 80% after deductible 100% after deductible 80% after deductible 100% after deductible		-	80% after deductible		80% after deductible
consultations)/Surgical Expenses Therapy and Rehabilitation Services	services) including dependent daughter	copayment	3070 and addition		a succession
consultations)/Surgical Expenses  Therapy and Rehabilitation Services  **Therapy and Rehabilitation Services**	Medical Care (including inpatient visits and	1000/ often deducatible	900/ offer ded	1000/ ofter deductible	900/ often deductible
		100% aπer deductible	ου% aπer deductible	100% aπer deductible	80% after deductible
		Therapy and Reha	bilitation Services		
Copayment, if any does not apply to Therapy visits prescribed for the treatment of Mental Health or Substance			ly to Therapy visits prescribe		or Substance Abuse
Physical Medicine  100% after \$20 copayment per provider per date of service  80% after deductible 100% after \$20 copayment per provider per date of service 80% after	Physical Medicine		80% after deductible		80% after deductible
Respiratory Therapy  100% after deductible  100% after deductible	Respiratory Therapy		uctible	<del>                                     </del>	luctible



	Performance Blue PPO		PPO Blue			
Benefit	In-Network	Out-of-Network	In-Network	Out-of-Network		
Speech & Occupational Therapy	100% after \$20 copayment per provider per date of service	80% after deductible	100% after \$20 copayment per provider per date of service	80% after deductible		
Spinal Manipulations & Acupuncture	100% after \$20 copayment perprovider per date of service	80% after deductible	100% after \$20 copayment per provider per date of service	80% after deductible		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy &Dialysis)	100% after deductible	80% after deductible	100% after deductible	80% after deductible		
		Mental Health / Su				
Inpatient	100% after deductible	80% after deductible	100% after deductible	80% after deductible		
Inpatient Detoxification/Rehabilitation	100% after deductible	80% after deductible	100% after deductible	80% after deductible		
Outpatient Mental Health-Includes Virtual Behavioral Health Visits	100% after \$15 copayment	80% after deductible	100% after \$15 copayment	80% after deductible		
Outpatient Substance Abuse Services	100% after \$15 copayment	80% after deductible Other Se	100% after \$15 copayment rvices	80% after deductible		
Allergy Extracts and Injections	100% after deductible	80% after deductible	100% after deductible	80% after deductible		
Autism Spectrum Disorder including Applied	100% after deductible	80% after deductible	100% after deductible	80% after deductible		
Autism Spectrum Disorder including Applied Behavior Analysis (6)	\$40,000 maximum per memb		\$40,000 maximum per member			
	(includes prescription		(includes prescription drug)  Not Covered			
Assisted Fertilization Procedures	Not Cove	80% after deductible				
Dental Services Related to Accidental Injury			100% after deductible	80% after deductible		
Diagnostic Services	(7) Member Savings Site:	Diagnostic services prescri	bed for the treatment of Mental Healt  (6) <b>Member Savings Site:</b>	n or Substance Abuse		
	100% after deductible		100% after deductible			
Advanced Imaging		80% after deductible		80% after deductible		
(MRI, CAT, PET scan, etc.)	All Other Network Providers:	80% after deductible	All Other Network Providers:			
	\$50 copayment then		\$50 copayment then			
	100% after deductible		100% after deductible			
Basic Diagnostic Services (standard imaging and lab/pathology)	(7) <b>Member Savings Site:</b> 100% after deductible		(6) <b>Member Savings Site:</b> 100% after deductible			
		80% after deductible		80% after deductible		
	All Other Network Providers:		All Other Network Providers:			
	\$50 copayment then		\$50 copayment then 100% after deductible			
Basic Diagnostic Services	100% after deductible (7) Freestanding Facility:		(6) Freestanding Facility:	-		
	100% after deductible		100% after deductible			
		80% after deductible		80% after deductible		
(diagnostic medical and allergy testing)	All Other Network Providers : \$50 copayment then		All Other Network Providers:			
	100% after deductible		\$50 copayment then 100% after deductible			
Durable Medical Equipment, Orthotics &						
Prosthetics	100% after deductible	80% after deductible	100% after deductible	80% after deductible		
Routine Eye Exam / Foot Care Services	100% after deductible	80% after deductible	100% after deductible	80% after deductible		
Haaring Aida	100% after deductible	80% after deductible	100% after deductible	80% after deductible		
Hearing Aids	Limit: Up to \$300 per ear 48 months after previous purchase		Limit: Up to \$300 per ear 48 months after previous purchase			
	100% after deductible 80% after deductible		100% after deductible 80% after deductible			
Home Health Care (8)	Limit: 120 visits/plan year		Limit: 120 visits/plan year			
Hospice	100% after deductible	80% after deductible	100% after deductible	80% after deductible		
Infertility Counseling, Testing & Treatment (9)	100% after deductible	80% after deductible	100% after deductible	80% after deductible		
Private Duty Nursing	100% after network		100% after network de			
Skilled Nursing Facility Care	100% after deductible	80% after deductible	100% after deductible	80% after deductible		
Transplant Services	100% after deductible	80% after deductible	100% after deductible	80% after deductible		
Precertification Requirements (10)	YES		YES			
Prescription Drug Program	Retail Drugs (30 day Supply)					
Hard Mandatory Generic (11)	\$10/ generic copay					
Defined by the National Pharmacy Network - Not	\$25 formulary brand copay					
Physician Network. Prescriptions filled at a non-	\$50 non-formulary brand copay					
network pharmacy are not covered. (12)	Maintenance Prescription Drug Third fill at Retail Pharmacy					
•	Ma	Maintenance Drugs through Mail Order or CVS (90-day Supply)				
Your plan uses the Comprehensive Formulary	\$20 generic copay					
with an Incentive Benefit Design (13,14)	\$50 formulary brand copay \$100 non-formulary brand copay					
<del></del>						

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 benefit summary.

- Your group's plan year is based on a Calendar Year, January 1 through December 31.
- 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 / Substance Abuse benefit.
- 4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply
- 5) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits.
- 6) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
- 7) Member Savings Sites are independent laboratories and x-ray / imaging centers that perform diagnostic services at a reduced rate as well as Ambulatory Surgical Centers that are multispecialty and those delivering surgeries. Many providers may send their services out to a hospital for processing causing a facility charge in addition to the professional component, resulting in higher cost share for the member. When members use a Member Savings Site they can be confident that they will pay a lower cost share (i.e. not encountering multiple copays).
- 8) 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 Covered Services section.
- 9) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Contact Highmark Customer Service for the exact benefit.
- 10) Highmark 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 occurred.

  11) Under the hard 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. Regardless if the patient or provider
- requested the brand name.

  12) 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 1-866-594-1732 or the website at Highmarkbcbs.com for a listing of those pharmacies who have agreed to do so.
- a listing of those pharmacies who have agreed to do so.

  13) 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 provision 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.
- 14) The Highmark formulary is an extensive list of Food & 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 clinical pharmacists and physicians and may, from time to time, be revised by the committee. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. With the Smart90 CVS Network, after two fills at a retail pharmacy that is not CVS you must choose between a 90-day supply through CVS retail pharmacy stores or through Express Scripts Mail Order Pharmacy.

## DISCLAIMER