Summary of Benefits

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

Benefit	Performance Blue PPO		PPO Blue	
	In-Network	Out-of-Network	In-Network	Out-of-Network
General Provisions				
PLAN YEAR (1)	**CALENDAR YEAR**			
Deductible (per plan year) Individual Family	$800 $1,600 If you and your spouse voluntarily complete the wellness requirements, the in-network deductible is **waived**.	$1,600 $3,200	$2,000 $4,000 If you and your spouse voluntarily complete the wellness requirements the in-network individual deductible will be reduced to $1,200 and the family deductible will be reduced to $2,400.	$2,400 $4,800
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the plan year) Individual Family	None None	$4,800 $9,600	None None	$4,800 $9,600
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	$8,150 $16,300	Not Applicable Not Applicable	$8,150 $16,300	Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits				
Retail Clinic Visits & Virtual Visits	100% after $15 copayment	80% after deductible	100% after $15 copayment	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $15 copayment	80% after deductible	100% after $15 copayment	80% after deductible
Specialist Office & Virtual Visits	100% after $30 copayment	80% after deductible	100% after $30 copayment	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Urgent Care Center Visits Copayment, if any, does not apply to Urgent Care visits prescribed for the treatment of Mental Health or Substance Abuse	100% after $15 copayment	80% after deductible	100% after $15 copayment	80% after deductible
Telemedicine (3)	100% (deductible does not apply)	Not Covered	100% (deductible does not apply)	Not Covered
Preventive Care (4)				
Routine Adult Physical exams	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Adult immunizations	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Colorectal cancer screening	100% (deductible does not apply)	80% after deductible	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)	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine and Medically Necessary: 100% (deductible does not apply)	80% after deductible	Routine and Medically Necessary: 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
Routine Pediatric Physical exams	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Pediatric immunizations	100% (deductible does not apply)	80% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible	100% (deductible does not apply)	80% after deductible
Emergency Services				
Emergency Room Services	100% after $100 copayment (waived if admitted)		100% after $100 copayment (waived if admitted)	
Ambulance – Emergency (5)	100% after deductible		100% after deductible	
Ambulance – Non-Emergency (5)	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)				
Hospital Inpatient	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible	100% after deductible	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
Medical Care (including inpatient visits and consultations)/**Surgical Expenses**	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Therapy and Rehabilitation Services				
Copayment, if any, does not apply to Therapy visits prescribed for the treatment of Mental Health or SubstanceAbuse				
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 deductible
Respiratory Therapy	100% after deductible		100% after deductible	

Benefit	Performance Blue PPO		PPO Blue	
	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 per provider 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 / Substance Abuse				
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	100% after $15 copayment	80% after deductible
Other Services				
Allergy Extracts and Injections	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Autism Spectrum Disorder including Applied Behavior Analysis (6)	100% after deductible $40,000 maximum per member per plan year (includes prescription drug)	80% after deductible	100% after deductible $40,000 maximum per member per plan year (includes prescription drug)	80% after deductible
Assisted Fertilization Procedures	Not Covered		Not Covered	
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible	100% after deductible	80% after deductible
Diagnostic Services	Copayment, if any, does not apply to Diagnostic services prescribed for the treatment of Mental Health or Substance Abuse			
Advanced Imaging (MRI, CAT, PET scan, etc.)	(7) **Member Savings Site:** 100% after deductible **All Other Network Providers:** $50 copayment then 100% after deductible	80% after deductible	(6) **Member Savings Site:** 100% after deductible **All Other Network Providers:** $50 copayment then 100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging and lab/pathology)	(7) **Member Savings Site:** 100% after deductible **All Other Network Providers:** $50 copayment then 100% after deductible	80% after deductible	(6) **Member Savings Site:** 100% after deductible **All Other Network Providers:** $50 copayment then 100% after deductible	80% after deductible
Basic Diagnostic Services (diagnostic medical and allergy testing)	(7) **Freestanding Facility :** 100% after deductible **All Other Network Providers :** $50 copayment then 100% after deductible	80% after deductible	(6) **Freestanding Facility:** 100% after deductible **All Other Network Providers:** $50 copayment then 100% after deductible	80% 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
Hearing Aids	100% after deductible Limit: Up to $300 per ear 48 months after previous purchase	80% after deductible	100% after deductible Limit: Up to $300 per ear 48 months after previous purchase	80% after deductible
Home Health Care (8)	100% after deductible Limit: 120 visits/plan year	80% after deductible	100% after deductible Limit: 120 visits/plan year	80% after deductible
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 deductible		100% after network deductible	
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 Hard Mandatory Generic (11) Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. (12) Your plan uses the Comprehensive Formulary with an Incentive Benefit Design (13,14)	**Retail Drugs (31 day Supply)** $10/ generic copay $25 formulary brand copay $50 non-formulary brand copay **Maintenance Prescription Drug Third fill at Retail Pharmacy** **Maintenance Drugs through Mail Order or CVS (90-day Supply)** $20 generic copay $50 formulary brand copay $100 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 benefit summary.

1) 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 covered.
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 MyHighmark.com for 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

The Laborers' District Council of Western Pennsylvania Welfare Fund and the Laborers' Combined Funds have prepared this summary for overview purposes only and all benefits effective are subject to the descriptions, definitions, and other details in the Welfare Fund Summary Plan Description and are tentative and subject to final review.

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