

Plan B 012117-01

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 | In Network | Out of Network |
|---|----------------------------------|--|
| General Provisions | | |
| Effective Date | 1/1/2023 | |
| Benefit Period(1) | Calendar Year | |
| Deductible (per benefit period) Excludes amounts over the allowed amount | | |
| Individual | \$500 | \$1,500 |
| Family | \$1,500 | \$4,500 |
| Plan Pays – payment based on the plan allowance | 80% after deductible | 60% after deductible |
| Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) Excludes amounts over the allowed amount | | |
| Individual | \$5,000 | \$15,000 |
| Family | \$15,000 | \$45,000 |
| Office/Clinic/Urgent Care Visits | | |
| Retail Clinic Visits & Virtual Visits | 80% after deductible | 60% after deductible |
| Primary Care Provider Office Visits | 80% after deductible | 60% after deductible |
| <i>Virtual Visits (with your PCP)</i> | 100% after \$25 copay | 60% after deductible |
| Specialist Office Visits | 80% after deductible | 60% after deductible |
| <i>Virtual Visits (with your specialist)</i> | 100% after \$25 copay | 60% after deductible |
| Urgent Care Center Visits | 100% after \$25 copay | 60% after deductible |
| Telemedicine Services- Teladoc (3) | 100% after \$10 copay | not covered |
| Preventive Care (4) | | |
| Routine Adult | | |
| Physical Exams | 100% (deductible does not apply) | 100% (deductible does not apply) |
| Adult Immunizations | 100% (deductible does not apply) | 100% (deductible does not apply) |
| Routine Gynecological Exams, including a Pap Test | 100% (deductible does not apply) | 100% (deductible does not apply) |
| Mammograms, Annual Routine | 100% (deductible does not apply) | 100% (deductible does not apply) |
| Mammograms, Medically Necessary | 80% after deductible | 60% after deductible |
| Diagnostic Services and Procedures | 100% (deductible does not apply) | 100% (deductible does not apply) |
| Routine Pediatric | | |
| Physical Exams | 100% (deductible does not apply) | 100% (deductible does not apply) |
| Pediatric Immunizations | 100% (deductible does not apply) | 100% (deductible does not apply) |
| Diagnostic Services and Procedures | 100% (deductible does not apply) | 100% (deductible does not apply) |
| Emergency Services | | |
| Emergency Room Services | 80% after deductible | 80% after deductible in-network deductible applies |
| Ambulance - Emergency and Non-Emergency | 80% after deductible | 80% after in-network deductible |
| Hospital and Medical / Surgical Expenses (including maternity) | | |
| Hospital Inpatient | 80% after deductible | 60% after deductible |
| Hospital Outpatient | 80% after deductible | 60% after deductible |
| Maternity (non-preventive facility & professional services) | 100% after deductible | 60% after deductible |
| Maternity for Dependent Daughters | 100% after deductible | 60% after deductible |
| Medical Care (including inpatient visits and consultations)/Surgical Expenses | 80% after deductible | 60% after deductible |
| Therapy and Rehabilitation Services | | |
| Physical Medicine | 80% after deductible | 60% after deductible |
| Respiratory Therapy | 80% after deductible | 60% after deductible |
| Speech Therapy | 80% after deductible | 60% after deductible |
| Occupational Therapy | 80% after deductible | 60% after deductible |
| Spinal Manipulations | 80% after deductible | 60% after deductible |

| Benefit | In Network | Out of Network |
|--|---|----------------------|
| Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) | 80% after deductible | 60% after deductible |
| Mental Health / Substance Abuse | | |
| Inpatient Mental Health Services | 80% after deductible | 60% after deductible |
| Inpatient Detoxification / Rehabilitation | 80% after deductible | 60% after deductible |
| Outpatient Mental Health Services (includes virtual behavioral health visits) | 100% after \$25 copay | 60% after deductible |
| Outpatient Substance Abuse Services | 100% after \$25 copay | 60% after deductible |
| Other Services | | |
| Allergy Extracts and Injections | 80% after deductible | 60% after deductible |
| Hearing Aid | 100% up to \$3,000 every three years; Includes repairs – deductible and OOP do not apply; No coverage after maximum met within 3 year frequency | |
| Applied Behavior Analysis for Autism Spectrum Disorder (5) | 80% after deductible | 60% after deductible |
| Assisted Fertilization Procedures | 80% after deductible | 60% after deductible |
| | Lifetime maximum benefit: \$10,000 for procedures, \$10,000 for prescriptions Limitations apply: Limited to 3 IVF cycles when medically necessary up to age 40. | |
| Dental Services Related to Accidental Injury | 80% after deductible | 60% after deductible |
| Diagnostic Services | | |
| Advanced Imaging (MRI, CAT, PET scan, etc.) | 80% after deductible | 60% after deductible |
| Standard Imaging | 80% after deductible | 60% after deductible |
| Diagnostic Medical | 80% after deductible | 60% after deductible |
| Pathology/Laboratory | 80% after deductible | 60% after deductible |
| Allergy Testing | 80% after deductible | 60% after deductible |
| Durable Medical Equipment, Orthotics and Prosthetics | 80% after deductible | 60% after deductible |
| Home Health Care | 80% after deductible | 60% after deductible |
| Hospice | 80% after deductible | 60% after deductible |
| Infertility Counseling, Testing and Treatment (6) | 80% after deductible | 60% after deductible |
| Private Duty Nursing | 80% after deductible | 60% after deductible |
| Skilled Nursing Facility Care | 80% after deductible | 60% after deductible |
| Transplant Services | 80% after deductible | 60% after deductible |
| Precertification Requirements (7) | No | No |

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 Calendar Year which runs from January 1 to December 31.

(2) Not Applicable

(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.

(7) 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.

Discrimination is Against the Law

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the claims administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Please note that your employer – and not the claims administrator – is entirely responsible for determining member eligibility and for the design of your plan/program; including, any exclusion or limitation described in the benefit Booklet.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY: 711).

Geb Acht: Wann du Deutsch schwetzschst, kannst du en Dolmetscher griegen, un iss die Hilf Koschdefrei. Kannst du die Nummer an deine ID Kard dahinner uffrue (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ប្រការចងចាំ ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នង កាតសម្គាល់របស់លោកអ្នក (TTY: 711) ។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyon tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yánífti'go, language assistance services, éí t'áá níik'eh, bee níká a'doowol, éí bee ná'ahót'i'. ID bee nééhózingo nanitinígíí bine'déé' (TTY: 711) jít' hodílnih.

ધ્યાન દે: યદિ આપ હિન્દી બોલતે હૈ, તો આપકે લરિ નશિલ્ક ભાષા સહાયતા સેવા ઉપલબ્ધ હૈ। આપકે સદસ્ય પહચાન (ID) કાર્ડ કે પીછે દરિ ગણ નંબર પર ફોન કરૈ। (TTY: 711).

توجه فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జ్ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้ทุก โดยไม่มีค่าใช้จ่าย โทรไปยัง หมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ધ્યાન દાનિહોસ: યદિ તપાઈ નેપાલી ભાષા બોલનુહુનુછ અને, તપાઈકા લાગિભાષા સહાયતા સેવાહરુ નશિલ્ક ઉપલબ્ધ હુનુછનુ। તપાઈકો આઈડી કાર્ડકો પછાડિ આગમ્મા રહેકો નમ્બર (TTY: 711) મા ફોન ગરુનુહોસ।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).