HIGHMARK. | PPO Blue

Wilkes Barre Area School District 10430991, 10430992, 10430993

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	January 1, 2025	
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual Family (Aggregate)	 $175 $525	 $350 $1,050
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 (Aggregate)	 none none	 $3,000 $6,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, 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	 $3,300 $6,600	 not applicable not applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $10 copay	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $10 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after $25 copay	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $25 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 $10 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)
Breast Cancer Screenings (annual routine and supplemental)	100% (deductible does not apply)	80% (deductible does not apply)
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	80% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Nutritional Therapy	100% (deductible does not apply)	80% after deductible
	Limit: 6 visits per benefit period. Covered for any diagnosis	
Prostate Cancer Screening	100% (deductible does not apply)	80% (deductible does not apply)
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(5)	100% after $150 copay (waived if admitted)	
Ambulance- Emergency and Non-Emergency (6)	80% (deductible does not apply) for emergencies 80% after deductible for non-emergencies	80% (deductible does not apply) for emergencies 80% after deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)(5)		

Benefit	In Network	Out of Network
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Outpatient Surgery (facility)	100% after deductible	80% after deductible
Surgical Services (professional)	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	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after deductible	80% after deductible
	limit: 36 visits/benefit period aggregate with speech therapy and occupational therapy - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Respiratory Therapy	100% after deductible	80% after deductible
Speech Therapy	100% after deductible	80% after deductible
	limit: 36 visits/benefit period aggregate with occupational therapy and physical medicine - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Occupational Therapy	100% after deductible	80% after deductible
	limit: 36 visits/benefit period aggregate with speech therapy and physical medicine - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Spinal Manipulations	100% after deductible	80% after deductible
	limit: 12 visits/benefit period. No age limit	
Cardiac Rehabilitation Therapy	100% after deductible	80% after deductible
	limit: Unlimited	
Infusion Therapy	100% after deductible	80% after deductible
Chemotherapy	100% after deductible	80% after deductible
Radiation Therapy	100% after deductible	80% after deductible
Dialysis	100% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	80% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after deductible	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
Autism Spectrum Disorder Including Applied Behavior Analysis (7)	100% after deductible	80% after deductible
	Limit: $40,000 per benefit period	
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	not covered	not covered
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diabetes Treatment Equipment and Supplies	100% after deductible	80% after deductible
Diabetes Education Program	100% after deductible	80% after deductible
Diabetes Care Management Program (DCMP) - Digitally Monitored, includes telehealth consult for the A1C test	100% (deductible does not apply) continuous glucose monitor sprints are limited to three (3) per benefit period.	Not covered
DCMP - All Other Telehealth Consults	100% (deductible does not apply)	Not covered
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, Prosthetics, and Ostomy Supplies	100% after deductible	80% after deductible
	Limit: No dollar limit	
Home Health Care	100% after deductible	80% after deductible
Hospice	100% after deductible	80% after deductible
	limit: 180 days/lifetime	

Benefit	In Network	Out of Network
Infertility Counseling, Testing	100% after deductible	80% after deductible
	Testing to determine infertility only	
Mammograms, Medically Necessary	100% (deductible does not apply)	80% (deductible does not apply)
Private Duty Nursing	100% after deductible	80% after deductible
	limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	limit: 100 days/benefit period	
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements (8)	Yes	Yes

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) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, and any qualified medical expense. Prescription drug expenses are subject to a separate prescription drug TMOOP.
(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 with enhancements (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. If ASD benefit period dollar maximum applies, only non-essential health benefits will accumulate
(8) 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.

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 Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (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។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក (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 serbisyong 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 yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ 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, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दिनुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुनुहुन्छ। तपाईंको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

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).

WILKES-BARRE AREA SCHOOL DISTRICT: PPO $175 AND PRESCRIPTION DRUG PLAN

Medical administered by Highmark Blue Shield[1] (HBS)
Prescription Drug administered by Express Scripts (ESI)
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2025 - 12/31/2025
Coverage For: Individual and Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.myhighmark.com or express-scripts.com or call 1-800-241-5704 (HBS), (570) 718-0433 (the Trust office), or 1-800-467-2006 (ESI). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-800-241-5704 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Network:** $175 individual / $525 family; **Out-of-Network:** $350 individual / $1,050 family.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. **The deductible runs on a calendar year basis.**
Are there services covered before you meet your deductible?	Network deductible does not apply to office visits, preventive care services, emergency room care, emergency medical transportation, and urgent care. Copayments and coinsurance amounts don't count toward the network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Medical:** *Network* $3,300 individual / $6,600 family (deductible, coinsurance, copayment, and other qualified medical expenses) *Out-of-Network* $3,000 individual / $6,000 family (coinsurance only). **Prescription Drug:** $3,300 individual / $6,600 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. **The out-of-pocket limit runs on a calendar year basis.**

WILKES-BARRE AREA SCHOOL DISTRICT: PPO $175 AND PRESCRIPTION DRUG PLAN

Medical administered by Highmark Blue Shield[1] (HBS)
Prescription Drug administered by Express Scripts (ESI)
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2025 - 12/31/2025
Coverage For: Individual and Family | **Plan Type:** PPO

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	**Network:** Premiums, balance billing charges, and health care this plan doesn't cover. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limit. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket limit. **Out-of-Network:** Copayments, deductibles, premiums, balance billing charges, mental health, substance abuse, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of network providers, visit www.myhighmark.com or call 1-800-241-5704. For a list of approved pharmacies, visit express-scripts.com.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

WILKES-BARRE AREA SCHOOL DISTRICT: PPO $175 AND PRESCRIPTION DRUG PLAN

Medical administered by Highmark Blue Shield[1] (HBS)
Prescription Drug administered by Express Scripts (ESI)
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2025 - 12/31/2025
Coverage For: Individual and Family | **Plan Type:** PPO

All **copayment** and **coinsurance** costs shown in this chart are **AFTER** your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limits, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copayment/visit (Deductible does not apply)	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. **Out-of-Network:** Preventive screening services are not subject to deductible.
	Specialist visit	$25 copayment/visit (Deductible does not apply)	20% coinsurance	
	Preventive care/screening/ immunization	No charge (Deductible does not apply)	20% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Precertification may be required.
If you need drugs to treat your illness or condition	Generic drugs	$10 copayment (retail) / $20 copayment (mail order)		Covers up to 30-day supply (retail prescription) or 90-day supply (mail order prescription). Certain preventive prescription drugs are paid for 100% by the plan. If you (and not your doctor) request a brand prescription drug when there is a generic equivalent available, you will be responsible for the price difference between the brand drug and generic plus the brand copayment. Please see "Important Questions" regarding the plan's out-of-pocket limit.
	Preferred brand drugs	$20 copayment (retail) / $40 copayment (mail order)		
	Non-preferred brand drugs	$35 copayment (retail) / $70 copayment (mail order)		
	Specialty drugs	$35 copayment (retail) / $70 copayment (mail order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Precertification may be required.
	Physician/surgeon fees	No charge	20% coinsurance	Precertification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	20% coinsurance	Precertification may be required.
	Inpatient services	No charge	20% coinsurance	Precertification may be required.

WILKES-BARRE AREA SCHOOL DISTRICT: PPO $175 AND PRESCRIPTION DRUG PLAN

Medical administered by Highmark Blue Shield[1] (HBS)
Prescription Drug administered by Express Scripts (ESI)
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2025 - 12/31/2025
Coverage For: Individual and Family | **Plan Type:** PPO

All **copayment** and **coinsurance** costs shown in this chart are **AFTER** your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limits, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$150 copayment/visit	$150 copayment/visit	Deductible does not apply for emergencies. Copayment waived if admitted as inpatient.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Deductible does not apply for emergencies.
	Urgent care	$25 copayment/visit Deductible does not apply.	20% coinsurance	The copayment, if any, does not apply to Urgent Care services prescribed for the treatment of mental health or substance abuse.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Precertification may be required. **Out-of-Network:** Failure to precertify will result in benefits payable being reduced by $500.
	Physician/surgeon fees	No charge	20% coinsurance	Precertification may be required.
If you are pregnant	Office visits	No charge	20% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Precertification may be required.
	Childbirth/delivery professional services	No charge	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). **Network:** The first visit to determine pregnancy is covered at no charge.
	Childbirth/delivery facility services	No charge	20% coinsurance	**Out-of-Network:** Failure to precertify will result in benefits payable being reduced by $500.

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All **copayment** and **coinsurance** costs shown in this chart are **AFTER** your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limits, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Precertification may be required.
	Rehabilitation services	No charge	20% coinsurance	**Combined Network and Out-of-Network:** limited to 36 combined physical medicine, occupational therapy, and speech therapy visits per benefit period. The limit, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. Precertification may be required.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	No charge	20% coinsurance	**Combined Network and Out-of-Network:** limited to 100 days per benefit period. Precertification may be required. **Out-of-Network:** Failure to precertify will result in benefits payable being reduced by $500.
	Durable medical equipment	No charge	20% coinsurance	Precertification may be required.
	Hospice services	No charge	20% coinsurance	**Combined Network and Out-of-Network:** limited to 180 days per lifetime. Precertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Habilitation services	• Routine eye care (Adult)
• Cosmetic surgery	• Hearing aids	• Routine foot care
• Dental care (Adult)	• Long-term care	• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Infertility treatment	• Non-emergency care when traveling outside the U.S. See http://www.bcbsglobalcore.com
• Chiropractic care	• Private-duty nursing	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. The Pennsylvania Department of Consumer Services at 1-877-881-6388. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Your plan administrator/employer.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$175
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$ 12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$175
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$245**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$175
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$ 5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$175
Specialist copayment	$25
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$ 2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$175
Copayments	$230
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$605**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact 1-800-241-5704.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, First Priority Life Insurance Company or First Priority Health, all of which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com; or for a paper copy, call 1-855-873-4106.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

The Claims Administrator/Insurer:

- 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/Insurer 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.

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Language Assistance:

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).

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

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

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 c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vose-même. Composez le numéro qui est au dos de votre carte d'identité (TTY: 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).

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

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).

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.

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.