

Tuscarora Intermediate Unit

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.

010289-24, 44, 74

| Benefit | In Network | Out of Network |
|--|--|----------------------------------|
| General Provisions | | |
| Effective Date | | |
| Benefit Period (1) | Contract Year | |
| Deductible (per benefit period) | | |
| Individual | \$750 | \$1,500 |
| Family | \$1,500 | \$3,000 |
| Plan Pays – payment based on the plan allowance | 100% after deductible | 80% after deductible |
| Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) | | |
| Individual | None | \$1,000 |
| Family | None | \$2,000 |
| 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 | \$ 7,900 | Not Applicable |
| Family | \$15,800 | Not Applicable |
| Office/Clinic/Urgent Care Visits | | |
| Retail Clinic Visits & Virtual Visits | 100% after \$30 copay | 80% after deductible |
| Primary Care Provider (PCP) Office Visits & Virtual Visits | 100% after \$20 copay | 80% after deductible |
| Specialist Office Visits & Virtual Visits | 100% after \$30 copay | 80% after deductible |
| Virtual Visit Provider Originating Site Fee | 100% after deductible | 80% after deductible |
| Urgent Care Center Visits | 100% after \$50 copay Copayment, if any, does not apply to Urgent Care Center Visits prescribed for the treatment of Mental Health or Substance Abuse | 80% after deductible |
| Telemedicine Services (3) | not covered | not covered |
| Preventive Care (4) | | |
| Routine Adult | | |
| Physical Exams | 100% (deductible does not apply) | not covered |
| 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% after deductible |
| BRCA-Related Genetic Counseling and Genetic Testing | 100% (deductible does not apply) | 80% after deductible |
| Diagnostic Services and Procedures | 100% (deductible does not apply) | 80% after deductible |
| Routine Pediatric | | |
| Physical Exams | 100% (deductible does not apply) | not covered |
| 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) | 100% after deductible | 100% after in-network deductible |
| Hospital and Medical / Surgical Expenses (including maternity) (5) | | |
| Hospital Inpatient | 100% after deductible | 80% after deductible |
| Hospital Outpatient | 100% after deductible | 80% after deductible |
| Maternity (non-preventive professional services) including dependent daughter | 100% after deductible | 80% after deductible |
| Medical Care (including inpatient visits and consultations) | 100% after deductible | 80% after deductible |
| Therapy and Rehabilitation Services | | |

| Benefit | In Network | Out of Network |
|--|--|--|
| Physical Medicine | 100% after \$30 copay Copayment, if any does not apply to Therapy Services prescribed for the treatment of Mental Health or Substance Abuse | 80% after deductible benefit maximum of 20 visits/benefit period Copayment, if any does not apply to Therapy Services prescribed for the treatment of Mental Health or Substance Abuse |
| Speech Therapy | 100% after \$30 copay Copayment, if any does not apply to Therapy Services prescribed for the treatment of Mental Health or Substance Abuse | 80% after deductible benefit maximum of 20 visits/benefit period Copayment, if any does not apply to Therapy Services prescribed for the treatment of Mental Health or Substance Abuse |
| Occupational Therapy | 100% after \$30 copay Copayment, if any does not apply to Therapy Services prescribed for the treatment of Mental Health or Substance Abuse | 80% after deductible benefit maximum of 20 visits/benefit period Copayment, if any does not apply to Therapy Services prescribed for the treatment of Mental Health or Substance Abuse |
| Respiratory Therapy | 100% after deductible | 100% after in-network deductible |
| Spinal Manipulations | 100% after \$30 copay | 80% after deductible |
| | limit: 25 visits/benefit period | |
| Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) | 100% after deductible | 80% after deductible |
| Mental Health / Substance Abuse | | |
| Inpatient Mental Health Services | 100% after deductible | 80% after deductible |
| Inpatient Detoxification / Rehabilitation | 100% after deductible | 80% after deductible |
| Outpatient Mental Health Services (includes virtual behavioral health visits) | 100% after \$30 copay | 80% after deductible |
| Outpatient Substance Abuse Services | 100% after \$30 copay | 80% after deductible |
| Other Services | | |
| Allergy Extracts and Injections | 100% after deductible | 80% after deductible |
| Autism Spectrum Disorder Applied Behavior Analysis (7) | 100% after deductible | 80% after deductible |
| Assisted Fertilization Procedures | not covered | not covered |
| Dental Services Related to Accidental Injury | 100% after deductible | 80% after deductible |
| Diagnostic Services | | |
| Advanced Imaging (MRI, CAT, PET scan, etc.) | 100% after deductible | 80% after deductible |
| Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing) | 100% after deductible | 80% after deductible |
| Mammograms, Medically Necessary | 100% (deductible does not apply) | 80% after deductible |
| Durable Medical Equipment, Orthotics and Prosthetics | 100% after deductible | 80% after deductible |
| Home Health Care | 100% after deductible | 80% after deductible |
| Hospice | 100% after deductible | 80% after deductible |
| Infertility Counseling, Testing and Treatment (8) | 100% after deductible | 80% after deductible |
| Private Duty Nursing | 100% after deductible | 100% after in-network deductible |
| Skilled Nursing Facility Care | 100% after deductible | 80% after deductible benefit maximum of 100 days/benefit period |
| Transplant Services | 100% after deductible | 80% after deductible |
| Precertification/Authorization Requirements (9) | 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 Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.

(3) 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 (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.

(8) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

(9) 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.

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield or Highmark Choice Company, which are independent licensees of the Blue Cross Blue Shield Association.

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>.

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

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 المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 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).

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.