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NTIC Blast Intermediate Unit 17 Plan E 10213083, 10213084, 10213085 Effective: 7-1-2020

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 ProvisionsEff | | |
| Benefit Period(1) | Calendar Year | |
| Deductible (per benefit period)  Individual  Family | $250  $750 | $500  $1,500 |
| 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 | none  none | $3,000  $9,000 |
| 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  Family | $8,150  $16,300 | not applicable  not applicable |
| Office/Clinic/Urgent Care Visits | | |
| Retail Clinic Visits & Virtual Visits | 100% after $20 copay | 80% after deductible |
| Primary Care Provider Office Visits & Virtual Visits | 100% after $20 copay | 80% after deductible |
| Specialist Office Visits & Virtual Visits | 100% after $40 copay | 80% after deductible |
| Virtual Visit Originating Site Fee | 100% after deductible | 80% after deductible |
| Urgent Care Center Visits | 100% after $40 copay | 80% after deductible |
| Telemedicine Services (3) | 100% after $15 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) |
| Mammograms, Annual Routine | 100% (deductible does not apply) | 80% after deductible |
| Mammograms, Medically Necessary | 100% (deductible does not apply) | 80% after deductible |
| Diagnostic Services and Procedures | 100% (deductible does not apply) | 80% (deductible does not apply) |
| **Routine Pediatric**  Physical Exams | 100% (deductible does not apply) | 80% (deductible does not apply) |
| Pediatric Immunizations | 100% (deductible does not apply) | 80% (deductible does not apply) |
| Diagnostic Services and Procedures | 100% (deductible does not apply) | 80% (deductible does not apply) |
| Emergency Services | | |
| Emergency Room Services | 100% after $50 copay (waived if admitted) | |
| Ambulance (includes coverage for wheelchair van transports) | 100% (deductible does not apply) for emergencies; 100% after deductible for non-emergencies | 100% (deductible does not apply) for emergencies; 80% after deductible for non-emergencies |
| Hospital and Medical / Surgical Expenses (including maternity) | | |
| 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% (deductible does not apply) | 80% after deductible |
| Maternity (non-preventive facility 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 $40 copay | 80% after deductible |
|  | limit: 20 visits/benefit period | |
| Respiratory Therapy | 100% after deductible | 80% after deductible |
| Speech Therapy | 100% after $40 copay | 80% after deductible |
|  | limit: 12 visits/benefit period | |
| Occupational Therapy | 100% after $40 copay | 80% after deductible |
|  | limit: 12 visits/benefit period | |
| Spinal Manipulations | 100% after $40 copay | 80% after deductible |
|  | limit: 12 visits/benefit period | |
| Cardiac Rehabilitation Therapy | 100% after deductible | 80% after deductible |
| 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 (5) | 100% after deductible | 80% after deductible |
| Limit: $40,000 annual maximum | |
| 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 $75 copay | 80% after deductible |
| Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing) | 100% after deductible | 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 |
|  | limit: 180 days/ lifetime maximum of 30 days can be used for continuous or inpatient care 10 days/ lifetime can be used for respite care | |
| Infertility Counseling, Testing and Treatment (6) | 100% after deductible | 80% after deductible |
| Private Duty Nursing | not covered | not covered |
| Skilled Nursing Facility Care | 100% after deductible | 80% after deductible |
|  | limit: 60 days/benefit period | |
| Transplant Services | 100% after deductible | 80% after deductible |
| Precertification Requirements (7) | Yes | Yes |
| Prescription Drugs | | |
| Prescription Drug Deductible  Individual  Family | none  none | |
| Prescription Drug Program (8)  Hard Mandatory Generic  Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.  Your plan uses the Comprehensive Formulary with an Incentive Benefit Design | **Retail Drugs (30-day Supply)**  $3 formulary low cost generic copay  $3 non-formulary low cost generic copay  $10 formulary generic copay  $10 non-formulary generic copay  $20 formulary brand copay  $35 non-formulary brand copay  **Maintenance Drugs through Mail Order (90-day Supply)**  $6 formulary low cost generic copay  $6 non-formulary low cost generic copay  $20 formulary generic copay  $20 non-formulary generic copay  $40 formulary brand copay  $70 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 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, 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 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. 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. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

(7) Be sure your provider is aware that Highmark Utilization Management must be contacted for authorization prior to a planned inpatient admission or within 48 hours of an emergency or unplanned inpatient admission. Also note that certain outpatient procedures require prior authorization. If authorization 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.

(8) At a retail or mail-order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled. The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. 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. With the Active Choice program, you must choose how you want to fill your maintenance prescription drugs. You may choose a retail pharmacy or your mail order program. If after two fills at a retail pharmacy you have not made your selection, you will need to pay full cost of the drug allowed by your plan for any future refills. You can change your selection at any time. Your plan requires that you use Alliance Rx Walgreens Prime specialty pharmacy for select specialty medications. To obtain medications for hemophilia, you must use a specific pharmacy, please contact member services for more details.

