

Calcium USA - Customized PPO Blue Smart \$500 80/50

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	Network	Out-of-Network
General Provisions		
Effective Date	04/01/2024	
Benefit Period (1)	Contract Year	
Deductible (per benefit period)		
Individual	\$500	\$1,000
Family	\$1,000	\$2,000
Plan Pays – payment based on the plan allowance	80% after deductible	50% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	None	\$6,000
Family	None	\$12,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copayments, 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	\$3,000	Not Applicable
Family	\$6,000	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$30 copayment	50% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after \$30 copayment	50% after deductible
Specialist Office Visits & Virtual Visits	100% after \$30 copayment	50% after deductible
Virtual Visit Provider Originating Site Fee	80% after deductible	50% after deductible
Urgent Care Center Visits	100% after \$100 copayment - copayment does not apply to Urgent Care Center Visits prescribed for the treatment of Mental Health or Substance Abuse	50% after deductible
Telemedicine Services (3)	100% after \$20 copayment	Not Covered
Preventive Care (4)		
Routine Adult		
Physical exams	100% (deductible does not apply)	50% after deductible
Adult immunizations	100% (deductible does not apply)	50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	50% (deductible does not apply)
Breast Cancer Screenings (annual routine and supplemental)	100% (deductible does not apply)	50% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	50% after deductible
Pediatric immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Emergency Services		
Emergency Room Services (5)	100% after \$300 copayment (waived if admitted)	
Ambulance – Emergency	80% after network deductible	
Ambulance – Non-Emergency (6)	80% after network deductible	50% after deductible
Hospital and Medical/Surgical Expenses (including maternity) (5)		
Hospital Inpatient	80% after deductible	50% after deductible
Outpatient Surgery	80% after deductible	50% after deductible
Maternity (non-preventive professional services) including dependent daughter	80% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)	80% after deductible	50% after deductible

Benefit	Network	Out-of-Network
Therapy and Rehabilitation Services		
Physical Medicine	100% after \$30 copayment	50% after deductible
	Benefit Limit: 30 visits/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Speech Therapy	100% after \$30 copayment	50% after deductible
	Benefit Limit: 30 visits/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Occupational Therapy	100% after \$30 copayment	50% after deductible
	Benefit Limit: 30 visits/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Respiratory Therapy	80% after deductible	50% after deductible
Spinal Manipulations	100% after \$30 copayment	50% after deductible
	Benefit Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	50% after deductible
Mental Health/Substance Abuse		
Inpatient Mental Health Services	80% after deductible	50% after deductible
Inpatient Detoxification/Rehabilitation	80% after deductible	50% after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	100% after \$30 copayment	50% after deductible
Outpatient Substance Abuse	100% after \$30 copayment	50% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	50% after deductible
Autism Spectrum Disorder Applied Behavior Analysis ⁽⁷⁾	80% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	Not Covered	Not Covered
Diagnostic Services	Copayments, if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse	
Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	50% after deductible
Mammograms (medically necessary)	100% (deductible does not apply)	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	50% after deductible
Home Health Care	80% after deductible	50% after deductible
	Benefit Limit: 30 visits/benefit period, aggregate with Visiting Nurse	
Hospice	80% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment ⁽⁸⁾	80% after deductible	50% after deductible
	80% after deductible	50% after deductible
Private Duty Nursing	Benefit Limit: 240 hours/benefit period	
	80% after deductible	50% after deductible
Skilled Nursing Facility Care	Benefit Limit: 60 days/benefit period	
Transplant Services	80% after deductible	50% after deductible
Precertification/Authorization Requirements ⁽⁹⁾	Yes	
Prescription Drugs		
Prescription Drug Deductible		
Individual	None	
Family	None	

Benefit	Network	Out-of-Network
Prescription Drug Program ⁽¹⁰⁾ SensibleRx Choice Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with Incentive Benefit Design. Select Specialty Drugs are Limited to a 31-day Supply	Retail Drugs (31/60/90-day Supply) Generic: \$10 / \$20 / \$30 copayment Formulary Brand: \$35 / \$70 / \$105 copayment Non-Formulary Brand: \$60 / \$120 / \$180 copayment Select Specialty Drugs are Limited to a 31-day Supply Specialty Drug \$200 copayment Exclusive Home Delivery Maintenance Drugs through Mail Order (90-day Supply) Generic: \$25 copayment Formulary Brand: \$88 copayment Non-Formulary Brand: \$150 copayment	

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.

Signature of Client Representative

Title

Date

- 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, copayments, 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.
- 10) 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 SensibleRx Choice, 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, unless your doctor requests that the brand drug be dispensed. With the Exclusive Home Delivery program, you can have your maintenance prescription drugs filled at a retail pharmacy location two times. After that, you must have your maintenance prescription drugs filled through the mail order program. Your plan requires that you use a specific specialty pharmacy for hemophilia medications. Please contact member services for more details. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary.

Benefits and/or benefit administration may be provided by or through Highmark Inc. d/b/a Highmark Blue Shield, which is an independent licensee of the Blue Cross Blue Shield Association.