HIGHMARK

Super Blue PlusQHDHP[1]
$1600 HDHP Mix-Emb
80% - N5

Effective Date	December 1, 2024	
Benefit Period[2] (used for Deductible and Coinsurances limits and certain benefit frequencies.)	Contract Year	
Note: All Services are subject to the Deductible unless otherwise specified.		
If you are enrolled as a "Family Plan", the "Family Plan" deductible, coinsurance limit and TMOOP apply. It is possible for one family member to satisfy each of these limits.		
Deductible (Applies to Medical and Prescription Drug benefits. Network and Non-Network Deductible dollars do not cross apply.)	**NETWORK**	**NON-NETWORK**
Employee Only Plan	$1,600	$20,000
Family Plan	$3,200	$40,000
Carry-Over Deductible Period	NONE	
Coinsurance Limit: (Applies to Medical and Prescription Drug benefits. Network and Non-Network Coinsurance dollars do not cross apply.)	**NETWORK**	**NON-NETWORK**
Employee Only Plan	$3,500	$6,000
Family Plan	$7,000	$12,000
Total Maximum Out–of-Pocket[3] (Includes Deductible, Copays, and Coinsurance per Benefit Period, Network only)	**NETWORK**	**NON-NETWORK**
Employee Only Plan	$5,100	Not Applicable
Family Plan	$10,200	Not Applicable
Non-Network Liability	UNLIMITED	
Lifetime Maximum Benefit for all Covered Services	UNLIMITED	

BENEFIT HIGHLIGHTS

	NETWORK	**NON-NETWORK**
Medical Office Visit / Office Consultation - (Includes Specialist / Specialist Virtual Visits)	80% after deductible	60% after deductible
Virtual Visit Originating Site	80% after deductible	60% after deductible
Urgent Care Center Visits	80% after deductible	60% after deductible
	Copayment, if any, does not apply to Urgent Care Center visits for the treatment of Mental Health and Substance Use Disorder	
Retail Clinic Visits	80% after deductible	60% after deductible
Telemedicine Service[4]	80% after deductible	No Benefits

PRESCRIPTION DRUGS[5]

	NETWORK	**NON-NETWORK**
Prescription Deductible		
Individual	Integrated with medical deductible	No Benefits
Family	Integrated with medical deductible	No Benefits
Retail Drugs through a Retail Pharmacy Network - Maximum 90 day Supply If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowances, in addition to the Co-Pay or Coinsurance, unless the Physician writes 'Brand Necessary' (DAW) on the prescription, or if no generic equivalent exists. **Note:** Prescription Deductibles, Copays and/or Coinsurance amounts apply toward the Total Maximum Out-of-Pocket.	80% after deductible Cost-sharing for Prescription Insulin Drugs will not exceed $35 for a 30-day supply Cost sharing for diabetic devices will not exceed $100 for a 30-day supply (deductible does not apply)	No Benefits
Maintenance Drugs through Mail Order - Maximum 90 day Supply If you choose Brand over Generic, you will pay the difference between the Brand and Generic Allowances, in addition to the Co-Pay or Coinsurance, unless the Physician writes 'Brand Necessary' (DAW) on the prescription, or if no generic equivalent exists. **Note:** Prescription Deductibles, Copays and/or Coinsurance amounts apply toward the Total Maximum Out-of-Pocket.	80% after deductible Cost-sharing for Prescription Insulin Drugs will not exceed $35 for a 30-day supply Cost sharing for diabetic devices will not exceed $100 for a 30-day supply (deductible does not apply)	No Benefits
Additional Preventive Prescription Benefits (Retail or Mail Order). Guidelines as determined by certain Governmental Agencies. You may access this information at www.healthcare.gov. You may also contact Member Services.	100%, No Deductible	No Benefits

PREVENTIVE CARE SERVICES (6,10)		
	NETWORK	**NON-NETWORK**
Routine Adult		
Physical exams	100%, No Deductible	60% after deductible
Adult immunizations	100%, No Deductible	60% after deductible
Colorectal cancer screening	100%, No Deductible	60% after deductible
Routine gynecological exams, including a Pap Test	100%, No Deductible	60%, No Deductible
Mammograms, annual routine	100%, No Deductible	60% after deductible
Diagnostic services and procedures	100%, No Deductible	60% after deductible
Routine Pediatric		
Physical exams	100%, No Deductible	60% after deductible
Pediatric immunizations	100%, No Deductible	60%, No Deductible
Diagnostic services and procedures	100%, No Deductible	60% after deductible
AUTISM SPECTRUM DISORDER[7]		
Services for diagnosis and treatment of Autism Spectrum Disorder (See Section V for additional information). Note: Covered Services will be paid according to the benefit category (e.g. Speech Therapy, Office Visit, etc.)	80% after deductible	60% after deductible
PHYSICIAN SERVICES		
In-Hospital Medical Visit	80% after deductible	60% after deductible
Skilled Nursing Facility Medical	80% after deductible	60% after deductible
Surgery, Assistant to Surgery, Anesthesia	80% after deductible	60% after deductible
Second Surgical Opinion Consultations (Outpatient)	80% after deductible	60% after deductible
Maternity Care - Dependent daughters are covered.	80% after deductible	60% after deductible
Newborn Care including circumcision.	80% after deductible	60% after deductible
Occupational Therapy (Rehabilitative and Habilitative) **Limit**: 30 visits per benefit period for other than chronic pain **Limit:** 30 visits per event for chronic pain[8] Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined. Limit, if any, does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	80% after deductible	60% after deductible Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder
Physical Therapy (Rehabilitative and Habilitative) **Limit**: 30 visits per benefit period for other than chronic pain **Limit:** 30 visits per event for chronic pain[8] Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined. Limit, if any, does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	80% after deductible	60% after deductible Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder
Spinal Manipulations **Limit**: 30 visits per benefit period for other than chronic pain **Limit:** 30 visits per event for chronic pain[8] Limitations are for Network and Non-Network	80% after deductible	60% after deductible
Respiratory Therapy	80% after deductible	60% after deductible
Cardiac Rehabilitation Therapy	80% after deductible	60% after deductible
Dialysis	80% after deductible	60% after deductible
Chemotherapy	80% after deductible	60% after deductible
Radiation Therapy	80% after deductible	60% after deductible

Infusion Therapy	80% after deductible	60% after deductible
Speech Therapy (Rehabilitative and Habilitative) when necessary due to a medical condition. Limit, if any, does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	80% after deductible Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder	60% after deductible
Temporomandibular Joint Dysfunction / Craniomandibular Disorders	80% after deductible	60% after deductible
Diagnostic, X-ray, Lab and Allergy Testing	80% after deductible	60% after deductible
Allergy Treatment, extractions and injections	80% after deductible	60% after deductible

INPATIENT HOSPITAL / FACILITY SERVICES		
	NETWORK	**NON-NETWORK**
Unlimited Days Semi-Private Room and Board	80% after deductible	60% after deductible
Ancillaries, Drugs, Therapy Services, X-ray and Lab	80% after deductible	60% after deductible
General Nursing Care	80% after deductible	60% after deductible
Surgical Services	80% after deductible	60% after deductible
Birthing Center Care / Maternity Services - Dependent daughters are covered.	80% after deductible	60% after deductible
OUTPATIENT HOSPITAL / FACILITY SERVICES		
Pre-Admission Testing	80% after deductible	60% after deductible
Diagnostic, X-ray, Lab and Testing	80% after deductible	60% after deductible
Surgery, Operating Room	80% after deductible	60% after deductible
Medically Necessary Mammogram	80% after deductible	60% after deductible
Occupational Therapy (Rehabilitative and Habilitative) **Limit**: 30 visits per benefit period for other than chronic pain **Limit:** 30 visits per event for chronic pain[8] Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined. Limit, if any, does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	80% after deductible Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder	60% after deductible
Physical Therapy (Rehabilitative and Habilitative) **Limit**: 30 visits per benefit period for other than chronic pain **Limit:** 30 visits per event for chronic pain[8] Limitations are for Physician & Outpatient Facility, Network and Non-Network, Rehabilitative and Habilitative, combined. Limit, if any, does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	80% after deductible Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder	60% after deductible
Respiratory Therapy	80% after deductible	60% after deductible
Cardiac Rehabilitation Therapy	80% after deductible	60% after deductible
Dialysis	80% after deductible	60% after deductible
Chemotherapy	80% after deductible	60% after deductible
Radiation Therapy	80% after deductible	60% after deductible
Infusion Therapy	80% after deductible	60% after deductible
Speech Therapy (Rehabilitative and Habilitative) when necessary due to a medical condition. Limit, if any, does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	80% after deductible Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health and Substance Use Disorder	60% after deductible
BEHAVIORAL HEALTH SERVICES (10)		
Outpatient Mental Health Services	80% after deductible	60% after deductible
Outpatient Substance Abuse Services	80% after deductible	60% after deductible
Inpatient Mental Health Care Services	80% after deductible	60% after deductible
Inpatient Substance Abuse Care Services	80% after deductible	60% after deductible
EMERGENCY CARE SERVICES		
Emergency Room Services (10)	80% after network deductible	
Ambulance **Emergency(ground, water, air)**	80% after network deductible	
Ambulance	80% after deductible	60% after deductible

Non-Emergency (ground, water)(9)		
Ambulance **Non-Emergency (air)**	80% after network deductible	

OTHER COVERED SERVICES		
	NETWORK	**NON-NETWORK**
Private Duty Nursing – **Maximum 35 visits per Benefit Period** Note: Maximums are Network and Non-Network combined.	80% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible	60% after deductible
Durable Medical Equipment and Oxygen at home		60% after deductible
	Cost sharing for eligible Diabetic Devices will not exceed $100 for a 30-day supply	
Orthotic Devices and Prosthetic Appliances	80% after deductible	60% after deductible
Home Health Care – Maximum100 Visits per Benefit Period Note: Maximums are Network and Non-Network combined.	80% after deductible	60% after deductible
Hospice Care	80% after deductible	60% after deductible

HUMAN ORGAN TRANSPLANT / BONE MARROW PROCEDURES		
	NETWORK	**NON-NETWORK**
Human Organ Transplant • Includes transportation, meals and lodging.	80% after deductible	60% after deductible
Bone Marrow Procedures • Includes transportation, meals and lodging.	80% after deductible	60% after deductible

Eligible Dependent Age Limitation	Coverage stops at the end of the month of the 26th birthday for an adult Dependent who qualifies as an Eligible Dependent.

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). On the chart above, 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.

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) 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.
(2) 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.
(3) 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.
(4) Telemedicine services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark designated telemedicine vendor. Additional services provided by a Highmark designated telemedicine vendor 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 outpatient mental
(5) 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. This formulary covers all FDA-approved generic and brand-name drugs. 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. Anti-Cancer medications orally administered or self-injected. Deductible, copayment and coinsurance amounts for patient administered anti-cancer medications that are covered benefits are applied on no less favorable basis than for provider injected or intravenously administered anti-cancer medications.

(6) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(7) After initial evaluation, applied behavioral analysis 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). Treatment for Autism Spectrum Disorders does not reduce visit/day limit.
(8) 30 visit maximum per event for combined physical therapy, occupational therapy and spinal manipulations
99)Unless otherwise provided for benefits for emergency ambulance services rendered by a non-network provider will be subject to the same cost-sharing amount, if any, that is applicable to network services. The member will be responsible for any amounts billed by the non-network provider for non-emergency ground and water ambulance services that are in excess of the amount that Highmark pays.
(10)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.
(11) Covered virtual services will be paid according to the benefit category (e.g., primary care provider office visit, maternity visit, etc.) For example, virtual visits relating to the treatment of mental illness or substance use disorder are covered under your outpatient mental health and substance use disorder benefit and subject to the cost sharing amount in excess of the plan allowance for such services.