Wilkes University - $400 Deductible

Client 116509; Group 10213308, 10213309

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, 2023 – December 31, 2023	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $400 $1,200	 $800 $2,400
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 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	 $7,150 $14,300	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $25 copay	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $25 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after $50 copay	80% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $50 copay	80% after deductible
Telemedicine Services (3)	not covered	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% (deductible does not apply)
Mammograms, Medically Necessary	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
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 $100 copay (waived if admitted)	
Ambulance – Emergency (6)	100% (deductible does not apply)	100% (deductible does not apply)
Ambulance - Non-Emergency (6)	100% after deductible	80% after 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 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	$50 copay after deductible, 100% thereafter limit: 20 visits/benefit period	80% after deductible

Benefit	In Network	Out of Network
Respiratory Therapy	100% after deductible	80% after deductible
Speech Therapy	$50 copay after deductible, 100% thereafter	80% after deductible
	limit: 12 visits/benefit period	
Occupational Therapy	$50 copay after deductible, 100% thereafter	80% after deductible
	limit: 12 visits/benefit period	
Spinal Manipulations	$50 copay after deductible, 100% thereafter	80% after deductible
	limit: 12 visits/benefit period	
Cardiac Rehabilitation Therapy	100% after deductible	80% after deductible
	limit: 36 visits/benefit period	
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
Applied Behavior Analysis for Autism Spectrum Disorder (7)	100% after deductible	80% after deductible
	limit: $40,000 annual maximum	
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	100% after deductible	80% after deductible
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	$75 copay after deductible, 100% thereafter	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	$50 copay after deductible, 100% thereafter	80% after deductible
Hospice	100% after deductible	80% after deductible
	limit: 180 days/lifetime	
Infertility Counseling, Testing and Treatment (8)	100% after deductible	80% after deductible
	Testing to determine infertility only	
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 (9)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	$100 none	

Benefit	In Network	Out of Network
Prescription Drug Program (10) 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 **Select Specialty Drugs are limited to a 31 day supply**	**Retail Drugs (31-day Supply)** $0 low cost generic copay $15 Formulary generic copay $15 Non-Formulary generic copay $30 Formulary brand copay $50 Non-Formulary brand copay **Active Choice** **Maintenance Drugs through Mail Order (90-day Supply)** $0 low cost generic copay $30 Formulary generic copay $30 Non-Formulary generic copay $70 Formulary brand copay $150 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) Telemedicine Services (acute care for minor illnesses available on-demand 24/7), must be performed by a Highmark approved telemedicine vendor. Additional services provided by an approved 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 health).
(4) Services are limited to those listed on the Highmark Preventive Schedule with enhancement (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) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits.
(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 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 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 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

Name: _____ Title: _____ Date: _____