HIGHMARK. PPO Blue

# Juniata College

## PPO Blue Sharing

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.

104071-79, 104071-80

| Benefit | Network | Out-of-Network |
|---|---|---|
| **General Provisions** | | |
| Benefit Period(1) | Contract Year | |
| Deductible (per benefit period)<br>Individual<br>Family | <br>$350<br>$700 | <br>$ 800<br>$1,600 |
| 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)<br>Individual<br>Family | <br>None<br>None | <br>$4,100<br>$8,200 |
| 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.<br>Individual<br>Family | <br>$3,550<br>$7,100 | <br>N/A<br>N/A |
| **Office/Clinic/Urgent Care Visits** | | |
| Retail Clinic Visits & Virtual Visits | 100% after $15 copay | 80% after deductible |
| Primary Care Provider Office Visits & Virtual Visits | 100% after $20 copay | 80% after deductible |
| Specialist Office & Virtual Visits | 100% after $30 copay | 80% after deductible |
| Virtual Visit Originating Site Fee | 100% | 80% after deductible |
| Urgent Care Center Visits | 100% after $30 copay | 100% after $30 copay |
| Maternity-Professional (including dependent daughter) | 100% after deductible | 80% after deductible |
| Telemedicine Services(3) | 100% after $10 copay | Not Covered |
| **Preventive Care(4)** | | |
| Routine Adult<br>Physical exams | <br>100% | <br>80% after deductible |
| Adult immunizations | 100% | 80% after deductible |
| Routine gynecological exams, including a Pap Test | 100% | 80% after deductible |
| Mammograms, annual routine | 100% | 80% after deductible |
| Mammograms & 3D Mammograms | 100% | 80% after deductible |
| Women's Health- Breast Feeding supplies All screenings, and counseling | 100% | 80% after deductible |
| Diagnostic services and procedures | 100% | 80% after deductible |
| Routine Pediatric<br>Physical exams | <br>100% | <br>80% after deductible |
| Pediatric immunizations | 100% | 80% after deductible |
| Diagnostic services and procedures | 100% | 80% after deductible |
| **Emergency Services** | | |
| Emergency Room Services | 100% after $100 copay (waived if admitted) | |
| Ambulance – Emergency (Non-Emergency, Ground, Air and Water) (9) | 100% (deductible does not apply) | |
| Non-Emergency & Non-Urgent use of Urgent Care provider | 100% after a $30 copay | 100% after a $30 copay |
| **Hospital and Medical/Surgical Expenses (including maternity)** | | |
| Hospital Inpatient | 100% after $100 copay (per admission) | 80% after deductible |
| Hospital Outpatient- Excludes emergency room services | 100% after $30 copay | 80% after deductible |
| Maternity (including dependent daughter) | 100% after $100 copay (per admission) | 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 $15 copay<br>Limit: 60 visits/benefit period | 80% after deductible |
| Speech, Occupational & Respiratory Therapy | 100% after $15 copay<br>Limit: 60 visits per therapy/benefit period | 80% after deductible |
| Spinal Manipulations | 100% after $15 copay<br>Limit: 25 visits/benefit period | 80% after deductible |
| Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) | 100% after deductible | 80% after deductible |
| Inpatient Mental Health Services | 100% after $100 copay (per admission) | 100% after $100 copay (per admission) |
| Inpatient Detoxification / Rehabilitation | 100% after $100 copay (per admission) | 100% after $100 copay (per admission) |
| Outpatient Mental Health Services (includes virtual behavioral health visits) | 100% after $15 copay | 100% after $15 copay |

| Benefit | Network | Out-of-Network |
|---|---|---|
| Outpatient Substance Abuse Services | 100% after $15 copay | 100% after $15 copay |
| **Other Services** | | |
| Allergy Extracts and Injections | 100% deductible waived | 80% after deductible |
| Autism Spectrum Disorder including Applied Behavior Analysis(5) | 100% after deductible | 80% after deductible |
| Infertility Treatment (diagnosis and treatment of the underlying medical condition only) | 100% after deductible | 80% after deductible |
| Contraceptives | 100% (deductible waived) | 80% after deductible |
| Vasectomy | 100% after deductible | 80% after deductible |
| Tubal ligation | 100% deductible waived | 80% after deductible |
| Diabetic Supplies | 100% deductible waived | 80% after deductible |
| Hearing Aids (Limited $1,000 per lifetime) | 100% deductible waived | 80% after deductible |
| Diagnostic Services<br>*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 |
| Durable Medical Equipment, Orthotics and Prosthetics | 100% deductible waived | 80% after deductible |
| Home Health Care | 100% after deductible<br>Limit: 120 visits/benefit period | 80% after deductible |
| Hospice | 100% after deductible | 80% after deductible |
| Infertility Counseling, Testing and Treatment(6) | 100% after deductible | 80% after deductible |
| Private Duty Nursing | 100% after deductible | 80% after deductible |
| Skilled Nursing Facility Care-Applies to Facility | 100% after $100 copay<br>Limit: 90 days/benefit period | 80% after deductible |
| Transplant Services | 100% after $100 copay | 80% after deductible |
| Precertification Requirements(7) | Yes | |
| **Prescription Drugs** | | |
| Prescription Drug Deductible (must be satisfied before any drug benefits are paid. For Retail Drugs only.)<br>Individual<br>Family | $50.00<br>$150.00 | |
| (Deductible waived for low cost generic, generic and mail order generic)<br><br>Prescription Drug Program(8)<br><br>Soft Mandatory Generic: the member pays the applicable copay. If the physician requires brand-name, member would pay brand-name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price<br><br>Prescriptions filled at a non-network pharmacy are not covered.<br><br>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design. | **Retail Drugs (31/60/90-day Supply)**<br>$3/$6/$9 low cost generic<br>$15/$30/$45 generic copay<br>**Formulary Brand (31/60/90-day Supply)**<br>10% (min $25; max $100)/ 10% ($40 min, $200 max)/ 10% ($60 min, $300 max)<br>**Non-formulary Brand (31/60/90-day Supply)**<br>10% (min $45; max $100) / 10% ($80 min, $300 max) / 10% (min $120, $400 max)<br>10% (min $25; max $150) preferred specialty<br>10% (min $45; max $150) non- preferred specialty<br><br>**Maintenance Drugs through Mail Order (90-day Supply)**<br>$6 low cost generic<br>$30 generic copay<br>$50 formulary brand copay<br>$90 non-formulary brand copay<br>10% (min $25; max $150) preferred specialty<br>10% (min $45; max $150) non- preferred specialty | |

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. Effective with plan years beginning on or after January 1, 2016, the TMOOP cannot exceed $3,550 for individual and $7,100 for two or more persons.

(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.

(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) 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.

(8) 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 soft 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, unless your doctor requests that the brand drug be dispensed. **The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment. If eligible members do not enroll in this money-saving program at no additional cost, then a new 30% coinsurance will**

**apply to certain high-cost medications. However, if eligible members enroll in Copay Armor, the manufacturer coupons will reduce out-of-pocket costs to $0 or a nominal fee, depending on the medication. Please note that when members use Copay Armor, only the amount a member pays for the prescription will apply towards the member's annual out-of-pocket maximum**.

(9) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.

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 complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- 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 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.

*Please note that your employer – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/ program; including, any exclusion or limitation described in the benefit Booklet.*

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).

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).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (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).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 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).

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.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 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).

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់របស់លោកអ្នក ( 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).

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).

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.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ధారాళం లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दिनुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। तपाईको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).