# Carbon Lehigh Intermediate Unit | PPO 750 Benefit Summary

**Act 93/Admin Group Number(s): Active 025481-06, COBRA 025481-07, Retiree 025481-08**
**Management/Professional/Support Group Number(s): Active 025481-18, COBRA 025481-19, Retiree 025481-20**
**CLEA Group Number(s): Active 025481-27, COBRA 025481-28, Retiree 025481-29**

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, 2025 | |
| Benefit Period (1) | Calendar Year | |
| Deductible (per benefit period)<br>Individual<br>Family | <br>$750<br>$1,500 | <br>$1,500<br>$3,000 |
| Plan Pays – payment based on the plan allowance | 90% after deductible | 70% after deductible |
| Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period)<br>Individual<br>Family | <br>$750<br>$1,500 | <br>$3,000<br>$6,000 |
| 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.<br>Individual<br>Family | <br><br><br><br>$9,200<br>$18,400 | <br><br><br><br>Not Applicable<br>Not Applicable |
| **Office/Clinic/Urgent Care Visits** | | |
| Retail Clinic Visits & Virtual Visits | 100% after $40 copay | 70% after deductible |
| Primary Care Provider (PCP) Office Visits & Virtual Visits | 100% after $20 copay | 70% after deductible |
| Specialist Office Visits & Virtual Visits | 100% after $40 copay | 70% after deductible |
| Virtual Visit Provider Originating Site Fee | 90% after deductible | 70% after deductible |
| Urgent Care Center Visits | 100% after $40 copay | 70% after deductible |
| Telemedicine Services (3) | 100% after $15 copay | not covered |
| **Preventive Care (4)** | | |
| **Routine Adult**<br>Physical Exams | <br>100% (deductible does not apply) | <br>70% after deductible |
| Adult Immunizations | 100% (deductible does not apply) | 70% after deductible |
| Routine Gynecological Exams, including a Pap Test | 100% (deductible does not apply) | 70% (deductible does not apply) |
| Breast Cancer Screenings (annual routine and supplemental) | 100% (deductible does not apply) | 70% after deductible |
| BRCA-Related Genetic Counseling and Genetic Testing | 100% (deductible does not apply) | 70% after deductible |
| Colorectal Cancer Screening | 100% (deductible does not apply) | 70% after deductible |
| Diagnostic Services and Procedures | 100% (deductible does not apply) | 70% after deductible |
| **Routine Pediatric**<br>Physical Exams | <br>100% (deductible does not apply) | <br>70% after deductible |
| Pediatric Immunizations | 100% (deductible does not apply) | 70% (deductible does not apply) |
| Diagnostic Services and Procedures | 100% (deductible does not apply) | 70% after deductible |
| **Emergency Services** | | |
| Emergency Room Services (5) | 100% after $100 copay (waived if admitted) | |
| Ambulance - Emergency and Non-Emergency (6) | 100% (deductible does not apply) | 100% (deductible does not apply) |
| **Hospital and Medical / Surgical Expenses (including maternity) (5)** | | |
| Hospital Inpatient | 90% after deductible | 70% after deductible |
| Hospital Outpatient | 90% after deductible | 70% after deductible |
| Outpatient Surgery (facility) | 90% after deductible | 70% after deductible |
| Surgical Services (professional) | 90% after deductible | 70% after deductible |
| Maternity (non-preventive professional services) including dependent daughter | 90% after deductible | 70% after deductible |
| Medical Care (including inpatient visits and consultations) | 90% after deductible | 70% after deductible |
| **Therapy and Rehabilitation Services** | | |
| Physical Medicine | 100% after $40 copay<br>limit: 20 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse | 70% after deductible |
| Speech Therapy | 100% after $40 copay<br>limit: 12 visit/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse | 70% after deductible |

| Benefit | In Network | Out of Network |
|---|---|---|
| Occupational Therapy | 100% after $40 copay | 70% after deductible |
| | limit: 12 visit/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse | |
| Respiratory Therapy | 90% after deductible | 70% after deductible |
| Spinal Manipulations | 100% after $40 copay | 70% after deductible |
| | limit: 20 visits/benefit period | |
| Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) | 90% after deductible | 70% after deductible |
| **Mental Health / Substance Abuse** | | |
| Inpatient Mental Health Services | 90% after deductible | 70% after deductible |
| Inpatient Detoxification / Rehabilitation | 90% after deductible | 70% after deductible |
| Outpatient Mental Health Services (includes virtual behavioral health visits) | 100% after $40 copay | 70% after deductible |
| Outpatient Substance Abuse Services | 100% after $40 copay | 70% after deductible |
| **Other Services** | | |
| Allergy Extracts and Injections | 90% after deductible | 70% after deductible |
| Autism Spectrum Disorder Applied Behavior Analysis (7) | 90% after deductible | 70% after deductible |
| Assisted Fertilization Procedures | not covered | not covered |
| Dental Services Related to Accidental Injury | not covered | not covered |
| **Diabetes Treatment** Equipment and Supplies | 90% after deductible | 70% after deductible |
| Diabetes Education Program | 90% after deductible | 70% after deductible |
| Diabetes Care Management Program (DCMP) - Digitally Monitored, includes telehealth consult for the A1C test | 100% (deductible does not apply) continuous glucose monitor sprints are limited to three (3) per benefit period. | not covered |
| DCMP - All Other Telehealth Consults | 100% (deductible does not apply) | not covered |
| **Diagnostic Services** Advanced Imaging (MRI, CAT, PET scan, etc.) | 90% after deductible | 70% after deductible |
| Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing) | 90% after deductible | 70% after deductible |
| Mammograms, Medically Necessary | 100% (deductible does not apply) | 70% after deductible |
| Durable Medical Equipment, Orthotics and Prosthetics | 90% after deductible | 70% after deductible |
| Home Health Care | 90% after deductible | 70% after deductible |
| | limit: 90 visits/benefit period aggregate with visiting nurse | |
| Hospice | 90% after deductible | 70% after deductible |
| Infertility Counseling, Testing and Treatment (8) | 90% after deductible | 70% after deductible |
| Private Duty Nursing | 90% after deductible | 70% after deductible |
| | limit: 240 hours/benefit period | |
| Skilled Nursing Facility Care | 90% after deductible | 70% after deductible |
| | limit: 100 days/benefit period | |
| Transplant Services | 90% after deductible | 70% after deductible |
| Precertification/Authorization Requirements (9) | Yes | Yes |
| **Prescription Drugs** | | |
| Prescription Drug Deductible<br>Individual<br>Family | none<br>none | |
| Prescription Drug Program (10)<br><br>Defined by the National Pharmacy Network - Not Physician Network.<br><br>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design | **Retail Drugs (30-day Supply)**<br>$27 Generic copay<br>$55 Formulary brand copay<br>$75 Non-Formulary brand copay<br><br>**Exclusive Home Delivery**<br>**Maintenance Drugs through Mail Order (90-day Supply)**<br>$60 Generic copay<br>$90 Formulary brand copay<br>$130 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 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 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. With the Exclusive Home Delivery program, you can have your maintenance prescription drugs filled two times at a retail pharmacy location. 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.

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  - Qualified sign language interpreters
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  - Qualified interpreters
  - Information written in other languages

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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.

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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).

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

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).

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).

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).

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).

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

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).

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