Benefit Information for Non-Permanent Employees Working an Average of 30 Hours a Week

This newsletter provides a benefit summary of the PPO plan that is offered to employees in Faculty/Coach (APSCUF), Nonrepresented, Nurses (OPEIU), or Safety/Police (POA/SPFPA) employee groups who qualify for benefits under the Affordable Care Act.

The Affordable Care Act (ACA) was enacted in 2010. The ACA requires employers to provide medical coverage to employees who work an average of at least 30 hours a week. Coverage is generally required to meet the following criteria:

1. *Minimum Value*—an employer-sponsored health plan that covers at least 60% of the total allowed cost of benefits that are expected to be incurred under the plan.
2. *Affordable Coverage*—the lowest cost self-only health plan option is 8.39% or less of an employee's household income.

- It has been determined that you qualify for this plan as an employee working an average of 30 hours per week. This determination is based on criteria established by the ACA, and not by language contained in the Collective Bargaining Agreements (CBAs) for employees in the Faculty/Coach (APSCUF) Nurses (OPEIU), or Safety/Police (POA/SPFPA) groups, or by policy for Nonrepresented employees.

- You and any of your eligible dependents may enroll in the ACA PPO Plan offered by the State System and administered by Highmark Blue Shield.

- Coverage does not begin automatically; you will need to enroll to begin coverage for yourself and, if you choose, your eligible dependents.

- Coverage elected during the open enrollment period will be effective July 1st of that year. For new hires or newly eligible employees, the coverage effective date will be your date of hire or when you became eligible for the ACA PPO Plan.

- Each plan year, you will have an opportunity during open enrollment either to enroll in coverage (if you remain ACA eligible), decline coverage, or add or remove dependents. If you experience a qualifying event during the year, you may be eligible to make changes in response to the event (e.g., add or remove dependents). Please be aware that if you enroll and later decide you no longer want the coverage, you may only drop your coverage upon a qualifying life event, or at the next open enrollment period.

- The State System ACA PPO plan does NOT include Dental or Vision Coverage.

This PPO Plan meets the minimum value standard mandated under ACA, but may <u>not</u> be affordable based upon your household income. You will need to determine whether or not this plan is deemed affordable based upon the plan cost and your household income. If this plan is deemed to be "unaffordable" based on your household income, you may be eligible to enroll in a health plan through the Health Insurance Marketplace and to receive a subsidy to assist you in paying for that coverage.

Your Options

- Enroll in the ACA PPO Plan offered by the State System.
- Decline to enroll in coverage through the State System.
- Other potential coverage options if you decline enrollment in the State System's ACA PPO plan:
  - If you have a spouse who is enrolled in his/her own employer's health plan, you may be eligible to enroll in that plan as a dependent.
  - If you are under the age of 26, you may be eligible to enroll as a dependent in a parent's employer-sponsored health plan.
  - If you are not covered under a health plan elsewhere, and if this plan is deemed to be "unaffordable," you may seek coverage from the Health Insurance Marketplace by visiting www.healthcare.gov. You may be eligible for a subsidy from the Marketplace to assist with the cost of the health plan in which you enroll.

You must make an election either to Enroll or Waive coverage.

Enrollment and changes are elected via the Self Service Portal. Follow the instructions below to make your election using Self Service Workplace.

- Log in to the State System's Self Service Workplace portal at https://workplace.passhe.edu/ (Use the same login credentials as you used for Employee Self Service)
- If you are adding any new family members to your plan that are not already listed in the "My Family Members" tile, navigate to the "Family Members" tile first to create the record for the new family member. (Refer to the My Family Members Help Document).
- Navigate to the My Benefits Enrollment tile to proceed with your plan enrollment. (Refer to the My Benefits Enrollment Help Document.)

Employee Biweekly Premium Contributions

For employees eligible for coverage under the terms of the Affordable Care Act

Rates effective July 1, 2025 for the Highmark PPO Blue Plan

Contract Type	Non-Represented/ OPEIU / POA / SPFPA Deductions based on 26-Pays	APSCUF Faculty / Coaches 26-Pay	Faculty 20-Pay
Single Contract	$440.66	$446.94	$581.02
Two-Party Contract	$976.94	$990.84	$1,288.10
Family Contract	$1,197.28	$1,214.31	$1,578.61

Current Deductibles and Coinsurance

The PPO plan includes deductibles and coinsurance for **certain types*** of medical services, per the chart below.

	Nonrepresented, OPEIU, POA, SPFPA		APSCUF Faculty and Coaches	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Deductible	$250 per person, $500 per family	$500 per person, $1,000 per family	$400 per person, $800 per family	$800 per person, $1,600 per family
Member Coinsurance	10%	30%	n/a	20%
Out-of-Pocket Maximum (Coinsurance)	$1,000 per person, $2,000 per family	$2,000 per person, $4,000 per family	n/a	$3,200 per person, $6,400 per family
Primary Care Physician Office Visit*	$15 copay (not subject to deductible or coinsurance)	30% after deductible	$20 copay (not subject to deductible)	20% after deductible
Specialist Office Visit*	$25 copay (not subject to deductible or coinsurance)	30% after deductible	$30 copay (not subject to deductible)	20% after deductible
Urgent Care*	$25 copayment	30% after deductible	$50 copay	20% after deductible
Emergency Room	$100 copayment (waived if admitted)	$100 copayment (waived if admitted)	$200 copayment (waived if admitted)	$200 copayment (waived if admitted)
Preventive Care*	Plan pays 100% - no deductible	30% after deductible	Plan pays 100% - no deductible	20% after deductible

Deductibles and coinsurance do not apply to in-network preventive care or to services for which a copay applies.

Preventive Care

There are no member costs for preventive care at in-network providers–the plan pays 100% of the costs for qualifying preventive services. By following the recommendations in the preventive schedule, you may be able to either prevent certain medical conditions, or detect them before they become more serious.

If your medical provider orders diagnostic tests/screenings that are not covered on the preventive schedule, those services may be subject to additional costs (e.g. Deductible and/or coinsurance)

Balance Billing

If you use an out-of-network provider, you may be subject to balance billing - the provider can bill the difference between the insurance allowance and their full charge, which can be significant.

For further details on your plan, please refer to the summary of benefits: Nonrepresented/Police/Nurses or Faculty/Coaches

Hearing Benefits

Employees and their eligible dependents who are enrolled in the ACA PPO Plan have a hearing plan which will provide a maximum benefit of $1,250 per ear every 36 months. This maximum benefit is inclusive of hearing aid examinations, and the purchase of hearing aids, including necessary, non-warranty covered repairs and maintenance of hearing aids. For further details, please see the Hearing Benefits Summary.

Prescription Drug Program Information

Copays for both retail and mail-order prescriptions are listed below:

Prescription Drug Tier	Retail Copay (30-day supply)	Mail-Order Copay (90-day supply)
Generic	$10	$ 20
Brand Drugs, Formulary	$30	$ 60
Brand Drugs, Nonformulary	$50	$100

Note–Prescription drugs are not subject to the plan deductible or coinsurance; the only member cost associated with this plan benefit are the copays listed above.

Certain prescription drugs are subject to prior authorization requirements, quantity level limits, or other management programs to ensure that these medications are being used in a safe and effective manner, and to help both you and the health plan control costs.

Specialty Medications
If you or a covered family member need(s) to take a specialty medication, you will be required to obtain the prescription from Accredo Specialty Pharmacy, a mail-order pharmacy provider solely focused on specialty medications. Accredo Specialty Pharmacy has negotiated with Highmark to provide the deepest discounts on specialty medications, which can average $5,000 or more in cost per month. Additionally, this vendor offers a dedicated care coordinator to provide support to patients.

What is a specialty medication?
Specialty medications are used to treat chronic, rare, or complex conditions (such as rheumatoid arthritis, multiple sclerosis, or cancer). Additionally, specialty medications may:
- Be given by infusion, injection, or taken orally.
- Cost more than traditional medications.
- Have special storage and handling requirements.
- Need to be taken on a very strict schedule.
- Have support programs and services available to help patients receive the most benefit from their medication.

Save Money and Time with Mail-Order

If you or a covered family member are (is) taking a maintenance medication, and you are purchasing it at a retail pharmacy, you will save money by switching to mail-order.

Although the mail-order copay is two times the retail copay, you get three times the amount of your prescription (a 90-day supply) with the mail-order service.

For example: if you are taking a brand name formulary drug, you will be spending $360 per year ($30 copay times12 refills) at the retail pharmacy. But, if you switch to mail-order, you will spend $240 per year ($60 copay times 4 refills) saving you $120 per year!

Additionally, mail-order is more convenient–saving you from making monthly trips to the pharmacy.

Call Highmark member services at 1-888-745-3212 or logon to https://myhighmark.com and navigate to the "Benefits" tab, select "Prescription", then "View Prescription Benefits" to find more information on the mail-order program.

Choose Generics
Ask your doctor to write your prescription for generic drugs when possible. Generics meet the same FDA standards as brand-name drugs, but both you and the health plan will pay less.

View the attached Prescription Benefits Summary for more information on the prescription drug plan

PPO Blue Benefit Summary for Nonrepresented, Nurses, and Police Employee Groups

HIGHMARK. | PPO Blue

State System of Higher Education – Management – Effective 1-1-2025

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.

Group Numbers: 02507902, 03, 04 and 05

Benefit	In Network	Out of Network
General Provisions		
Effective Date	January 1, 2025	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $250 $500	 $500 $1,000
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) Individual Family	 $1,000 $2,000	 $2,000 $4,000
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	 $9,200 $18,400	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $25 copay	70% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $15 copay	70% after deductible
Specialist Office Visits & Virtual Visits	100% after $25 copay	70% after deductible
Virtual Visit Provider Originating Site Fee	90% after deductible	70% after deductible
Urgent Care Center Visits	100% after $25 copay	70% after deductible
Telemedicine Services (3)	100% after $10 copay	Not Covered
Preventive Care with Enhancements (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 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 Prostate Cancer Screening (Males age 19 and over)	100% (deductible does not apply)	70% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 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) for emergencies; 90% after deductible for non-emergencies	100% (deductible does not apply) for emergencies; 70% after deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	90% after deductible	70% after deductible
	Limit: 365 days/admission	
Hospital Outpatient	90% after deductible	70% after deductible
Outpatient Surgery (facility)	90% after deductible	70% after deductible
Surgical Services (professional) (except office visits) Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, excludes neonatal circumcisions	90% after deductible	70% after deductible
Maternity (non-preventive professional services) including dependent daughter	90% after deductible	70% after deductible

Benefit	In Network	Out of Network
Medical Care (including inpatient visits and consultations)	90% after deductible	70% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $25 copay	70% after deductible
Speech and Occupational Therapy	100% after $25 copay	70% after deductible
	Limit: 30 visits per type of therapyt/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 $25 copay	70% after deductible
	Limit: 30 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 $25 copay	70% after deductible
Outpatient Substance Abuse Services	100% after $25 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	90% after deductible	70% after deductible
Diabetes Treatment		
Equipment and Supplies	100%	80% after deductible
Diabetes Education Program	100%	80% after deductible
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: 60 visits/benefit period aggregate with visiting nurse	
Hospice	90% after deductible	70% after deductible
	Limit: 180 days/benefit period	
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 Individual/Family	None	
Prescription Drug Program (10) SensibleRx Choice Defined by the National Pharmacy Network - Not Physician Network. OON Retail Rx Claims – Member Files Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (30-day Supply)** $10 Formulary and Non-Formulary generic copay $30 Formulary brand copay $50 Non-Formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $20 Formulary and Non-Formulary generic copay $60 Formulary brand copay $100 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 with Enhancements (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. 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. Your plan requires that you use Accredo specialty pharmacy for select specialty medications. 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.

PPO Blue Benefit Summary for APSCUF (Faculty/Coach) Employee Groups

HIGHMARK. PPO Blue

State System of Higher Education- Faculty – Effective 1-1-2025

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.

Group Numbers: 02507900, 06

Benefit	In Network	Out of Network
General Provisions		
Effective Date	January 1, 2025	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) Individual Family	 $400 $800	 $800 $1,600
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	 $3,200 $6,400
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	 $9,200 $18,400	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $25 copay	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $20 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after $30 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
	copay, if any, does not apply to urgent care center visits prescribed for the treatment of mental health or substance abuse	
Telemedicine Services (3)	100% after $10 copay	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)
Breast Cancer Screenings (annual routine and supplemental)	100% (deductible does not apply)	80% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	80% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Prostate Cancer Screening (Males age 19 and older)	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 $200 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency (6)	100% (deductible does not apply) for emergency services; 100% after deductible for non-emergencies	100% (deductible does not apply) for emergency services; 80% after deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	100% after deductible	80% after deductible
	Limit: 365 days/admission	
Hospital Outpatient	100% after deductible	80% after deductible
Outpatient Surgery (facility)	100% after deductible	80% after deductible
Surgical Services (professional) Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, excludes neonatal circumcisions	100% after deductible	80% after deductible

Benefit	In Network	Out of Network
Maternity (non-preventive professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $30 copay	80% after deductible
Speech and Occupational Therapy	100% after $30 copay	80% after deductible
	Limit: 30 visit per type of therapy/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Respiratory Therapy	100% after deductible	80% after deductible
Spinal Manipulations	100% after $30 copay	80% after deductible
	Limit: 30 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and 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 $30 copay	80% after deductible
Outpatient Substance Abuse Services	100% after $30 copay	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	100% after deductible	80% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diabetes Treatment		
Equipment and Supplies	100% after deductible	80% after deductible
Diabetes Education Program	100% after deductible	80% after deductible
Diagnostic Services		
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
Mammograms, Medically Necessary	100% (deductible does not apply)	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	Limit: 60 visits/benefit period aggregate with visiting nurse	
Hospice	100% after deductible	80% after deductible
	Limit: 180 days/benefit period	
Infertility Counseling, Testing and Treatment (8)	100% after deductible	80% after deductible
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Precertification/Authorization Requirements (9)	Yes	Yes
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Prescription Drug Deductible Individual/Family	**None**	
Prescription Drug Program (10) SensibleRx Choice Defined by the National Pharmacy Network - Not Physician Network. OON Rx Claims – Member Files Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (30-day Supply)** $10 Formulary and Non-Formulary generic copay $30 Formulary brand copay $50 Non-Formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $20 Formulary and Non-Formulary generic copay $60 Formulary brand copay $100 Non-Formulary brand copay	

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(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 with Enhancements (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. 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. Your plan requires that you use Accredo specialty pharmacy for select specialty medications. 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.

State System of Higher Education
Prescription Drug Card Program
Summary of Benefits – Effective 1-1-2025

PRESCRIPTION DRUG	RETAIL PHARMACY	MAIL SERVICE PHARMACY
Deductible	None	
Prescription Drug Defined by the National Pharmacy Network - Not Physician Network.	**30 day supply** $10 Generic Copay $30 Brand Formulary Copay $50 Brand Non-Formulary Copay	**90 day supply** $20 Generic Copay $60 Brand Formulary Copay $100 Brand Non-Formulary Copay
Formulary	Comprehensive	
Formulary Benefit Design	Incentive	
Generic Substitution	Soft -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 physician requests that the brand name drug be dispensed	
Claim Submission	Pharmacy Files at Point-of-Sale	
Non-Network Pharmacy	Member Files Claim	
PRESCRIPTION DRUG CATEGORIES		
Contraceptives (oral and injectable)	Covered	
Fertility Agents	Covered	
Fluoride Products	Covered	
Insulin and Diabetic Supplies	Covered	
Smoking Deterrents (prescription)	Covered	
Vitamins (prescription)	Covered	
Weight Loss Drugs	Covered	
Prescription Hair Growth Products	Not Covered	
CARE MANAGEMENT PROGRAMS		
Exclusive Pharmacy Provider	Applies - selected high cost prescription drugs are covered only when they are dispensed through an exclusive pharmacy provider.	
Quantity Level Limits on selected prescription drugs	Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines.	
Managed Rx Coverage on selected prescription drugs	Applies – certain drug therapies may be monitored for appropriate usage and subject to case evaluation if recommended guidelines are exceeded.	
Managed Prior Authorizations	Applies on select high cost drugs	

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. Your plan requires that you use Accredo specialty pharmacy for select specialty medications. 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.

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State System of Higher Education
Hearing Summary of Benefits

<table>
<tr><th>Benefit</th><th>Coverage</th></tr>
<tr><td colspan="2">The following hearing aid services are covered when provided by a physician or when prescribed by a physician and provided by an audiologist or hearing aid dealer/fitter:</td></tr>
<tr><td>♦Hearing aid evaluation tests (to determine the type and make of hearing aid to best correct a hearing problem).</td><td rowspan="3">The following hearing aid services are covered at 100% of the plan allowance, whichever is less, up to $1,250 per ear per 36 – month period.

Highmark Blue Shield payments are made directly to Participating Providers. For services of Non- Participating Providers, Highmark Blue Shield makes payment on the Same basis, directly to the member.</td></tr>
<tr><td>♦Purchase of the following types of hearing aids:
◦In the ear
◦Behind the ear, including air and bone conduction types
◦On the body
◦Eyeglass type hearing aids, which are covered and payable in the same manner as behind the ear hearing aids</td></tr>
<tr><td>♦Necessary repairs and maintenance when provided after the expiration of the warranty.</td></tr>
<tr><th colspan="2">Limitations</th></tr>
<tr><td colspan="2">♦Payment for a hearing aid is limited to one hearing aid in any 36- month period.
♦A maximum amount of $1,250 per ear can be allowed per 36 – month period for hearing aid evaluation tests, hearing aid purchase and necessary repairs for maintenance.
♦The hearing aid evaluation test and/or hearing aid must be provided within six (6) months of an audiometric examination.
♦Doctor office visit, ear examinations, and audiometric examinations are not covered under this plan.
♦Benefits after Termination: Hearing aids ordered when coverage is in effect and delivered within 90 days after termination date.
♦Replacement of lost or stolen hearing aids is not covered.</td></tr>
</table>

*This exhibit provides general information. Detailed information about benefits and eligibility are contained in the benefit plan documents.