

## State System of Higher Education – Faculty – Effective 7-1-2020

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
<b>General Provisions</b>		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$400	\$800
Family	\$800	\$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)		
Individual	None	\$3,200
Family	None	\$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	\$8,150	Not Applicable
Family	\$16,300	Not Applicable
<b>Office/Clinic/Urgent Care Visits</b>		
Retail Clinic Visits & Virtual Visits	100% after \$25 copay	80% after deductible
Primary Care Provider 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 Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after \$50 copay	80% after deductible
Telemedicine Services(3)	100% after \$10 copay	Not Covered
<b>Preventive Care with Enhancements (4)</b>		
<b>Routine Adult</b>		
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 and Medically Necessary	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 over)	100% (deductible does not apply)	80% after deductible
<b>Routine Pediatric</b>		
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
<b>Emergency Services</b>		
Emergency Room Services	100% after \$200 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency	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
<b>Hospital and Medical / Surgical Expenses (including maternity)</b>		
Hospital Inpatient	100% after deductible	80% after deductible
	Limit: 365 days/admission	
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)	100% after deductible	80% after deductible
Surgical Expenses (except office visits) Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, excludes neonatal circumcisions	100% after deductible	80% after deductible
<b>Therapy and Rehabilitation Services</b>		
Physical Medicine	100% after \$30 copay	80% after deductible
Respiratory Therapy	100% after deductible	80% after deductible

<b>Benefit</b>	<b>In Network</b>	<b>Out of Network</b>
Speech and Occupational Therapy	100% after \$30 copay Limit: 30 visit per type of therapy/benefit period	80% after deductible
Spinal Manipulations	100% after \$30 copay Limit: 30 visits/benefit period	80% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
<b>Mental Health / Substance Abuse</b>		
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
<b>Other Services</b>		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	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
<b>Diagnostic Services</b>		
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% after deductible	80% after deductible
Home Health Care	100% after deductible Limit: 60 visits/benefit period aggregate with visiting nurse	80% after deductible
Hospice	100% after deductible Limit: 180 days/benefit period	80% after deductible
Infertility Counseling, Testing and Treatment (6)	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible Limit: 240 hours/benefit period	80% after deductible
Skilled Nursing Facility Care	100% after deductible Limit: 100 days/benefit period	80% after deductible
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements (7)	Yes	Yes
<b>Prescription Drugs</b>		
Prescription Drug Deductible Individual/Family	None	
Prescription Drug Program (8) Soft Mandatory Generic 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	<p style="text-align: center;"><b>Retail Drugs (30-day Supply)</b> \$10 Formulary and Non-Formulary generic copay \$30 Formulary brand copay \$50 Non-Formulary brand copay</p> <p style="text-align: center;"><b>Maintenance Drugs through Mail Order (90-day Supply)</b> \$20 Formulary and Non-Formulary generic copay \$60 Formulary brand copay \$100 Non-Formulary brand copay</p>	

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) 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 benefit.

(4) Services are limited to those listed on the Highmark Preventive Schedule with Enhancements (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.

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).

ATENCION: 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).

ATTENTION: If you speak Hindi, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

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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).

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).

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ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) angeführte Nummer an.

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

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Kominike: Si se Kreyol Ayisyen ou pale, gen sevis entepret, gratis-ticheri, ki la pou edwe. Rele nan nimewo ki nan do katidantite w la (TTY: 711).

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ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para voce no seu idioma. Ugué para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga ibreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ATTENTION: If you speak Hindi, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

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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).

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ध्यान दनुहोस्: यदि तपाईं नेपाली भाषा बोलनुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। तपाईंको 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).