

## NTIC Northern Tioga SD PPO Blue Plan E 10213112, 10213113, 10213114

### Effective: 7-1-2024

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	\$250	\$500
Family	\$750	\$1,500
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	\$3,000
Family	none	\$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	\$9,450	not applicable
Family	\$18,900	not applicable
<b>Office/Clinic/Urgent Care Visits</b>		
Retail Clinic Visits & Virtual Visits	100% after \$20 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 \$40 copay	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after \$40 copay	80% after deductible
	Copayment, 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 \$15 copay	not covered
<b>Preventive Care (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)
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
Diagnostic Services and Procedures	100% after deductible	80% (deductible does not apply)
<b>Routine Pediatric</b>		
Physical Exams	100% (deductible does not apply)	80% (deductible does not apply)
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% after deductible	80% (deductible does not apply)
<b>Emergency Services</b>		
Emergency Room Services (5)	100% after \$50 copay (waived if admitted)	
Ambulance (includes coverage for wheelchair ambulance transports) (6)	100% (deductible does not apply) for emergencies; 100% after deductible for non-emergencies	100% (deductible does not apply) for emergencies; 80% after deductible for non-emergencies
<b>Hospital and Medical / Surgical Expenses (including maternity)</b>		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive professional services) including dependent daughter	100% (deductible does not apply)	80% after deductible
Maternity (non-preventive facility 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

Benefit	In Network	Out of Network
<b>Therapy and Rehabilitation Services</b>		
Physical Medicine	100% after \$40 copay Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health or Substance Abuse limit: 20 visits/benefit period Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	80% after deductible
Respiratory Therapy	100% after deductible	80% after deductible
Speech Therapy	100% after \$40 copay Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health or Substance Abuse limit: 12 visits/benefit period Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	80% after deductible
Occupational Therapy	100% after \$40 copay Copayment, if any, does not apply to Therapy Services prescribed for the treatment of Mental Health or Substance Abuse limit: 12 visits/benefit period Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	80% after deductible
Spinal Manipulations	100% after \$40 copay limit: 12 visits/benefit period	80% after deductible
Cardiac Rehabilitation Therapy	100% after deductible	80% after deductible
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
<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 deductible	80% after deductible
Outpatient Substance Abuse Services	100% after deductible	80% after deductible
<b>Other Services</b>		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (7)	100% after deductible Limit: \$40,000 annual maximum	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 \$75 copay Copayments, if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Durable Medical Equipment and Orthotics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
Hospice	100% after deductible limit: 180 days/ lifetime maximum of 30 days can be used for continuous or inpatient care 10 days/ lifetime can be used for respite care	80% after deductible
Infertility Counseling, Testing and Treatment (8)	100% after deductible	80% after deductible
Private Duty Nursing	not covered	not covered
Skilled Nursing Facility Care	100% after deductible limit: 60 days/benefit period	80% after deductible
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements (9)	Yes	Yes
<b>Prescription Drugs</b>		
Prescription Drug Deductible Individual Family		none none

Benefit	In Network	Out of Network
<p>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.</p> <p>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design</p>		<p style="text-align: center;"><b>Retail Drugs (30-day Supply)</b></p> <p style="text-align: center;">\$3 low cost generic copay  \$3 formulary low cost generic copay  \$3 non-formulary low cost generic copay  \$10 formulary generic copay  \$10 non-formulary generic copay  \$20 formulary brand copay  \$35 non-formulary brand copay</p> <p style="text-align: center;"><b>Maintenance Drugs through Mail Order (90-day Supply)</b></p> <p style="text-align: center;">\$6 low cost generic copay  \$6 formulary low cost generic copay  \$6 non-formulary low cost generic copay  \$20 formulary generic copay  \$20 non-formulary generic copay  \$40 formulary brand copay  \$70 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) 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. 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 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 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.

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield, First Priority Health or First Priority Life, all of 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）。

CHỦ 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 Deutsch schwetzsch, kannst du en Dolmetscher grieve, un iss die Hilf Koschdfrei. Kannst 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 المساعدة 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).

ប្រាកដថា: បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាភាសាជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នង កាតសម្គាល់របស់លោកអ្នក ( 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 yánilti'go, language assistance services, éí t'áá níik'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'déé' (TTY: 711) jí' hodíílnih.

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

توجه 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 మాట్లాడతే, లాగ్ వేక్ అసినటినన్ సర్వీసెన్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్సాయ్. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐఐ) వెనుక ఉన్స నంబరుకు కాలి చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้ถูก โดยไม่มีค่าใช้จ่าย โทรไปแจ้ง หมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दनुहोस्: यदतिपाई नेपाली भाषा बोलनुहुन्छ भने, तपाईका लागि भाषा सहायता सेवाहरू नऱिशुल्क 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).