Reilly, McDevitt & Henrich, P.C.- PPO Blue $15-$35
Group Number(s): 108217-69, -70

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	Janaury 01, 2025	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 None None	 $2,500 $5,000
Plan Pays – payment based on the plan allowance	100%	50% 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	 $10,000 $20,000
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	 $7,900 $15,800	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $15 copay	50% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $15 copay	50% after deductible
Specialist Office Visits & Virtual Visits	100% after $35 copay	50% after deductible
Virtual Visit Provider Originating Site Fee	100%	50% after deductible
Urgent Care Center Visits	100% after $70 copay - copay does not apply to urgent care center visits prescribed for the treatment of mental health or substance abuse	50% after deductible
Telemedicine Services (3)	100%	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100%	 50% after deductible
Adult Immunizations	100%	50% after deductible
Routine Gynecological Exams, including a Pap Test	100%	50% (deductible does not apply)
Breast Cancer Screenings (annual routine and supplemental)	100%	50% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100%	50% after deductible
Colorectal Cancer Screening	100%	50% after deductible
Diagnostic Services and Procedures	100%	50% after deductible
Routine Pediatric Physical Exams	 100%	 50% after deductible
Pediatric Immunizations	100%	50% (deductible does not apply)
Diagnostic Services and Procedures	100%	50% after deductible
Emergency Services		
Emergency Room Services (5)	100% after $200 copay (waived if admitted)	
Ambulance - Emergency (6)	100%	100% (deductible does not apply)
Ambulance - Non-Emergency (6)	100%	50% after program deductible
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	100% after $150 inpatient copay/day; benefit maximum of 5 inpatient copays/admission	50% after deductible
Hospital Outpatient	100%	50% after deductible
Surgical Services (professional)	100%	50% after deductible

Benefit	In Network	Out of Network
Maternity (non-preventive professional services) including dependent daughter	100%	50% after deductible
Medical Care (including inpatient visits and consultations)	100%	50% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $35 copay	50% after deductible
	limit: 30 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Speech Therapy	100% after $35 copay	50% after deductible
	limit: 20 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Occupational Therapy	100% after $35 copay	50% after deductible
	limit: 30 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Respiratory Therapy	100%	50% after deductible
Spinal Manipulations	100% after $35 copay	50% after deductible
	limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	50% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after $150 inpatient copay/day; benefit maximum of 5 inpatient copays/admission	50% after deductible
Inpatient Detoxification / Rehabilitation	100% after $150 inpatient copay/day; benefit maximum of 5 inpatient copays/admission	50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $35 copay	50% after deductible
Outpatient Substance Abuse Services	100% after $35 copay	50% after deductible
Other Services		
Allergy Extracts and Injections	100%	50% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	100%	50% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	not covered	not covered
Diabetes Treatment		
Equipment and Supplies	100%	50% after deductible
Diabetes Education Program	100%	50% after deductible
Diabetes Care Management Program (DCMP) - Digitally Monitored, includes telehealth consult for the A1C test	100% continuous glucose monitor sprints are limited to three (3) per benefit period.	not covered
DCMP - All Other Telehealth Consults	100%	not covered
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after $70 copay - copay does not apply to diagnostic services prescribed for the treatment of mental health or substance abuse	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after $35 copay - copay does not apply to diagnostic services prescribed for the treatment of mental health or substance abuse	50% after deductible
Mammograms, Medically Necessary	100%	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	50% after deductible
Home Health Care	100%	50% after deductible
	limit: 90 visits/benefit period aggregate with visiting nurse	
Hospice	100%	50% after deductible
Infertility Counseling, Testing and Treatment (8)	100%	50% after deductible
Private Duty Nursing	100%	50% after deductible
	limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after $75 inpatient copay/day; benefit maximum of 5 inpatient copays/admission	50% after deductible
	limit: 120 days/benefit period	

Benefit	In Network	Out of Network
Transplant Services	100%	50% after deductible
Precertification/Authorization Requirements (9)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	 none none	
Prescription Drug Program (10) SensibleRx Choice Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design **Select Specialty Drugs are limited to 31-day Supply**	**Retail Drugs (31/60/90-day Supply)** $3 / $6 / $9 Formulary low cost generic copay $3 / $6 / $9 Non-Formulary low cost generic copay $15 / $30 / $45 Formulary generic copay $15 / $30 / $45 Non-Formulary generic copay $35 / $70 / $105 Formulary brand copay $50 / $100 / $150 Non-Formulary brand copay 50% for Formulary Specialty generic drugs $500 Maximum per Prescription 50% for Non-Formulary Specialty generic drugs $500 Maximum per Prescription 50% for Formulary Specialty brand drugs $500 Maximum per Prescription 50% for Non-Formulary Specialty brand drugs $500 Maximum per Prescription **Maintenance Drugs through Mail Order (90-day Supply)** $6 Formulary low cost generic copay $6 Non-Formulary low cost generic copay $30 Formulary generic copay $30 Non-Formulary generic copay $70 Formulary brand copay $100 Non-Formulary brand copay 50% for Formulary Specialty generic drugs $500 Maximum per Prescription 50% for Non-Formulary Specialty generic drugs $500 Maximum per Prescription 50% for Formulary Specialty brand drugs $500 Maximum per Prescription 50% for Non-Formulary Specialty brand drugs $500 Maximum per Prescription	

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.

Signature of Client Representative _____ Title _____ Date _____

(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.
(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. 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 a specific specialty pharmacy for hemophilia medications. Please contact member services for more details. 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. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary.

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The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- 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/Insurer 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.

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

If you speak English, language assistance services, free of charge, are available to you. Call 1-888-269-8412.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-888-269-8412.

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請致電 1-888-269-8412.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-888-269-8412.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다.
1-888-269-8412 로 전화.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-888-269-8412.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-888-269-8412.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-888-269-8412 .

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-888-269-8412.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-888-269-8412.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-888-269-8412.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-888-269-8412.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-888-269-8412.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-888-269-8412.

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اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان
با تماس با شماره 1-888-269-8412 .