# Cornwall Lebanon School District – Choice Blue PPO Benefit Summary

**Group Number(s): 105276-62; 106217-43, -47**

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out-of-pocket. 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 Enhanced Value | In-Network Standard Value | Out of Network |
|---|---|---|---|
| **General Provisions** | | | |
| Effective Date | January 1, 2024 | | |
| Benefit Period (1) | Calendar Year | | |
| Deductible (per benefit period) (All in-network services are credited to both enhanced and standard deductibles.)<br>Individual<br>Family | <br>$1,000<br>$2,000 | <br>$1,500<br>$3,000 | <br>$2,000<br>$4,000 |
| Plan Pays – payment based on the plan allowance | 100% after deductible | 80% after deductible | 80% 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>None<br>None | <br>$50<br>$100 | <br>$1,000<br>$2,000 |
| 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>$6,350<br>$12,700 | | <br>Not Applicable<br>Not Applicable |
| **Office/Clinic/Urgent Care Visits** | | | |
| Retail Clinic Visits & Virtual Visits | 100% after $25 copay | 80% after $25 copay | 80% after deductible |
| Primary Care Provider (PCP) Office Visits & Virtual Visits | 100% after $25 copay | 80% after $25 copay | 80% after deductible |
| Specialist Office Visits & Virtual Visits | 100% after $40 copay | 80% after $40 copay | 80% after deductible |
| Virtual Visit Provider Originating Site Fee | 100% after deductible | 80% after deductible | 80% after deductible |
| Urgent Care Center Visits | 100% after $25 copay | 80% after $25 copay | 80% after deductible |
| Telemedicine Services (3) | 100% after $25 copay | 100% after $25 copay | not covered |
| **Preventive Care (4)** | | | |
| **Routine Adult**<br>Physical Exams | <br>100% (deductible does not apply) | | <br>80% after deductible |
| Adult Immunizations | 100% (deductible does not apply) | | 80% after deductible |
| Colorectal Cancer Screenings | 100% (deductible does not apply) | | 80% after deductible |
| Contraceptives | 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 | 100% (deductible does not apply) | | 80% after deductible |
| Diagnostic Services and Procedures | 100% (deductible does not apply) | | 80% after deductible |
| **Routine Pediatric**<br>Physical Exams | <br>100% (deductible does not apply) | | <br>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 $100 copay (waived if admitted) | | |
| Ambulance - Emergency (6) | 100% (deductible does not apply) | | |
| Ambulance - Non-Emergency (6) | 100% (deductible does not apply) | | 80% after deductible |
| **Hospital and Medical / Surgical Expenses (including maternity) (5)** | | | |
| Hospital Inpatient | 100% after deductible | 80% after deductible | 80% after deductible |
| Hospital Outpatient | 100% after deductible | 80% after deductible | 80% after deductible |
| Maternity (non-preventive professional services) including dependent daughter | 100% after deductible | 80% after deductible | 80% after deductible |
| Medical Care (including inpatient visits and consultations) | 100% after deductible | 80% after deductible | 80% after deductible |

| Benefit | In-Network Enhanced Value | In-Network Standard Value | Out of Network |
|---|---|---|---|
| **Therapy and Rehabilitation Services** | | | |
| Physical Medicine (including rehabilitative services and habilitative services | 100% after $25 copay | 80% after $25 copay | 80% 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 (including rehabilitative services and habilitative services) | 100% after $25 copay | 80% after $25 copay | 80% after deductible |
| | limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse | | |
| Occupational Therapy (including rehabilitative services and habilitative services) | 100% after $25 copay | 80% after $25 copay | 80% after deductible |
| | limit: 12 visits/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 | 80% after deductible |
| Spinal Manipulations (including rehabilitative services and habilitative services) | 100% after deductible | 80% after deductible | 80% after deductible |
| | limit: 20 visits/benefit period | | |
| Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) | 100% after deductible | 80% after deductible | 80% after deductible |
| **Mental Health / Substance Abuse** | | | |
| Inpatient Mental Health Services | 100% after enhanced in-network deductible | | 80% after deductible |
| Inpatient Detoxification / Rehabilitation | 100% after enhanced in-network deductible | | 80% after deductible |
| Outpatient Mental Health Services (includes virtual behavioral health visits) | 100% after $25 copay | | 80% after deductible |
| Outpatient Substance Abuse Services | 100% after $25 copay | | 80% after deductible |
| **Other Services** | | | |
| Allergy Extracts and Injections | 100% after deductible | 80% after deductible | 80% after deductible |
| Applied Behavior Analysis for Autism Spectrum Disorder (7) | 100% after deductible | 80% after deductible | 80% after deductible |
| Assisted Fertilization Procedures | not covered | not covered | not covered |
| Dental Services Related to Accidental Injury | not covered | not covered | not covered |
| **Diagnostic Services**<br>Advanced Imaging (MRI, CAT, PET scan, etc.) | 100% after deductible | 80% after deductible | 80% after deductible |
| Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing) | 100% after deductible | 80% after deductible | 80% after deductible |
| Mammograms, Medically Necessary | 100% (deductible does not apply) | | 80% after deductible |
| Durable Medical Equipment and Orthotics | 100% after deductible | 80% after deductible | 80% after deductible |
| Prosthetic Devices | 100% after deductible | 100% after deductible | 100% after deductible |
| | benefit maximum of $300/lifetime for wigs | | |
| Home Health Care | 100% after deductible | 80% after deductible | 80% after deductible |
| | limit: 90 visits/benefit period aggregate with visiting nurse | | |
| Hospice | 100% after enhanced in-network deductible | | 80% after deductible |
| Infertility Counseling, Testing and Treatment (8) | 100% after deductible | 80% after deductible | 80% after deductible |
| Private Duty Nursing | 100% after deductible | 80% after deductible | 80% after deductible |
| | limit: 240 hours/benefit period | | |
| Routine Cost Associated with Approved Clinical Trials | 100% after deductible | 80% after deductible | 80% after deductible |
| Skilled Nursing Facility Care | 100% after deductible | 80% after deductible | 80% after deductible |
| | limit: 100 days/benefit period | | |
| Transplant Services | 100% after enhanced in-network deductible | | 80% after deductible |
| Blue Distinction Centers for Transplant (BDCT) Travel Expenses | 100% after deductible | 80% after deductible | not covered |
| | limit: $10,000 per transplant episode | | |
| Vision Care for Illness or Accidental Injury | 100% after deductible | 80% after deductible | 80% after deductible |
| Precertification/Authorization Requirements (9) | Yes | Yes | Yes |
| **Prescription Drugs** | | | |
| Prescription Drug Deductible<br>Individual<br>Family | none<br>none | | |
| Contraceptives | 100% (deductible does not apply) | | |
| Prescription Drug Program (10)<br>SensibleRx Complete<br><br>Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.<br><br>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design<br><br>**Select Specialty Drugs are limited to 31-day Supply** | **Retail Drugs (31/60/90-day Supply)**<br>$10 / $20 / $30 Generic copay<br>$35 / $70 / $105 Formulary brand copay<br>$50 / $100 / $150 Non-Formulary brand copay<br><br>**Maintenance Drugs through Mail Order (90-day Supply)**<br>$20 Generic copay<br>$70 Formulary brand copay<br>$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.
*The terms "Enhanced Value" and "Standard Value" are not descriptors of the provider's ability.

(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) After initial evaluation, Applied Behavioral Analysis 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). Treatment for Autism Spectrum Disorders does 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 SensibleRx Complete, 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. Your plan requires that you use Accredo specialty pharmacy for select specialty medications.

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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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