Summary of Benefits - FMHG PPO 750-1500 025245-02

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	01/01/2025	
Benefit Period (1)	Calendar Year	
Deductible (per benefit period) (All services are credited to both in-network and out-of-network deductibles.) Individual Family	 $750 $1,500	 $3,000 $6,000
Plan Pays – payment based on the plan allowance	90% after deductible	50% after deductible
Out-of-Pocket Limit (Includes coinsurance and deductible. Once met, plan pays 100% coinsurance for the rest of the benefit period) (All services are credited to both in-network and out-of-network out-of-pocket limits.) Individual Family	 $1,000 $2,000	 $4,250 $8,500
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 $35 copay	50% after deductible
Primary Care Provider 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	90% after deductible	50% after deductible
Urgent Care Center Visits	100% after $35 copay	50% after deductible
Telemedicine Services (3)	100% after $15 copay	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 not covered
Adult Immunizations	100% (deductible does not apply)	not covered
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	not covered
Mammograms, Annual Routine	100% (deductible does not apply)	not covered
Mammograms, Medically Necessary	90% after deductible	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	not covered
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 not covered
Pediatric Immunizations	100% (deductible does not apply)	not covered
Diagnostic Services and Procedures	100% (deductible does not apply)	not covered
Emergency Services		
Emergency Room Services	100% after $100 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency (5)	90% after deductible	90% after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	90% after deductible	50% after deductible
Hospital Outpatient	90% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	90% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	90% after deductible	50% after deductible

Benefit	In Network	Out of Network
Therapy and Rehabilitation Services		
Physical Medicine	100% after $35 copay	50% after deductible
	limit: 36 visits/benefit period aggregate with acupuncture, speech and occupational therapy. Additional visits require prior approval. Limit does not apply when therapy services are prescribed for the treatment of Mental Health or Substance Abuse.	
Respiratory Therapy	90% after deductible	90% after in-network deductible
Speech Therapy	100% after $35 copay	50% after deductible
	limit: 36 visits/benefit period aggregate with acupuncture, physical medicine and occupational therapy. Additional visits require prior approval. 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: 36 visits/benefit period aggregate with speech therapy and physical medicine. Additional visits require prior approval. Limit does not apply when therapy services are prescribed for the treatment of Mental Health or Substance Abuse.	
Spinal Manipulations	90% after deductible	50% after deductible
	limit: 12 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	50% after deductible
Acupuncture	90% after deductible	50% after deductible
	limit: 36 visits/benefit period aggregate with occupational therapy, speech therapy and physical medicine	
Mental Health / Substance Abuse		
Inpatient Mental Health Services	90% after deductible	50% after deductible
Inpatient Detoxification / Rehabilitation	90% after deductible	50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $15 copay if billed by PCP or $35 copayment if billed by Specialist	50% after deductible
Outpatient Substance Abuse Services	100% after $15 copay if billed by PCP or $35 copayment if billed by Specialist	50% after deductible
Other Services		
Allergy Extracts and Injections	90% (deductible does not apply)	50% after deductible
Assisted Fertilization Procedures	90% after deductible	50% after deductible
	limit: $10,000/per person/lifetime	
Dental Services Related to Accidental Injury	90% after deductible	50% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	50% after deductible
Outpatient Diagnostic Services	90% after deductible	50% after deductible
Standard Imaging	90% after deductible	50% after deductible
Diagnostic Medical	90% after deductible	50% after deductible
Pathology/Laboratory	90% after deductible	50% after deductible
Allergy Testing	90% (deductible does not apply)	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	50% after deductible
Home Health Care	90% after deductible	50% after deductible
Hospice	90% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (6)	90% after deductible	50% after deductible
Private Duty Nursing	90% after deductible	90% after in-network deductible
Skilled Nursing Facility Care	90% after deductible	50% after deductible
	limit: 100 days/benefit period	
Transplant Services	90% after deductible	50% after deductible
Transplant Travel, Lodging, Meals *$5,000 per transplant for the accompanying adult when pre-transplant evaluation, harvesting, stabilization and actual transplant is received by the recipient*	90% after deductible	Not covered
Precertification/Authorization Requirements (7)	Yes	Yes

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 (Women's Health Preventive Schedule may apply).
(5) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
(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) 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.

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Discrimination is Against the Law

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.

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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）。

CHÚ 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).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (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).

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).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 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).

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).

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

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).

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.

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.