

NFTA PPO 6300 - $10/$10 (0T02) - 10663293, 301, 309, 10772328, 29

On the chart below, you'll see what you pay 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 | **JANUARY 1** |
| Benefit Period (1) | Calendar Year |
| Deductible (per benefit period)  |  |  |
| Individual | $1,500 | $3,000 |
| Family | $3,000 | $6,000 |
| Deductible Accumulation (2) | Non-Embedded | Non-Embedded |
| Coinsurance - payment based on the plan allowance | 0% after deductible | 30% after deductible |
| **Out-of-Pocket Maximum** (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses). Once met, the plan pays 100% of covered services for the rest of the benefit period. |  |  |
| Individual | $5,000 | None |
| Family | $10,000 | None |
| Out-of-Pocket Accumulation (2) | Embedded | Not applicable |
| Office/Urgent Care Visits |
| Primary Care Provider Office Visits & Virtual Visits | $10 copay after deductible | 30% after deductible |
| Specialist Office Visits & Virtual Visits | $10 copay after deductible | 30% after deductible |
| Virtual Visit Provider Originating Site Fee | $0 after deductible | 30% after deductible |
| Urgent Care Center Visits | $35 copay after deductible | $35 copay after in-network deductible |
| Telemedicine Services (3) | $10 copay after deductible | not covered |
| Preventive Care (4) |
| **Routine Adult** |  |  |
| Physical Exams | covered in full | not covered |
| Adult Immunizations | covered in full | 30% after deductible |
| Routine Gynecological Exams, including a Pap Test | covered in full | 30% after deductible |
| Mammograms, Annual Routine | covered in full | 30% after deductible |
| Mammograms, Medically Necessary | $10 copay after deductible | 30% after deductible |
| Diagnostic Services and Procedures | covered in full | 30% after deductible |
| **Routine Pediatric** |  |  |
| Physical Exams | covered in full | 30% after deductible |
| Pediatric Immunizations | covered in full | 30% after deductible |
| Diagnostic Services and Procedures | covered in full | 30% after deductible |
| Emergency Services |
| Emergency Room Services | $50 copay (waived if admitted) after deductible; $35 copay for freestanding urgent care facility after deductible | $50 copay (waived if admitted) after in-network deductible; $35 copay for freestanding urgent care facility after in-network deductible |
| Ambulance - Emergency and Non-Emergency | $50 copay after deductible | $50 copay after in-network deductible |
| Hospital and Medical / Surgical Expenses (including maternity) |
| Hospital Inpatient | $0 after deductible | 30% after deductible |
| Outpatient Surgery | $10 copay after deductible | 30% after deductible |
| Maternity (non-preventive professional services) including dependent daughter | $10 copay after deductible | 30% after deductible |
| Medical Care (including inpatient visits and consultations) | $0 after deductible | 30% after deductible |
| Therapy and Rehabilitation Services |
| Physical Therapy | $10 copay after deductible | 30% after deductible |
| limit: 60 visits/benefit period aggregate with occupational therapy and speech therapy |
| Respiratory Therapy | $10 copay after deductible | 30% after deductible |
| Speech Therapy | $10 copay after deductible | 30% after deductible |
| limit: 60 visits/benefit period aggregate with occupational therapy and physical medicine |
| Occupational Therapy | $10 copay after deductible | 30% after deductible |
| limit: 60 visits/benefit period aggregate with speech therapy and physical medicine |
| Spinal Manipulations | $10 copay after deductible | 30% after deductible |
| Cardiac Rehabilitation Therapy | $10 copay after deductible | 30% after deductible |
| limit: 24 visits/benefit period |
| Infusion Therapy | $10 copay after deductible; $0 after deductible for home infusion | 30% after deductible |
| Chemotherapy | $10 copay after deductible | 30% after deductible |
| Radiation Therapy | $10 copay after deductible | 30% after deductible |
| Dialysis | $10 copay after deductible; $0 after deductible for home dialysis | 30% after deductible |
| Mental Health / Substance Abuse |
| Inpatient Mental Health Services | $0 after deductible | 30% after deductible |
| Inpatient Detoxification / Rehabilitation | $0 after deductible | 30% after deductible |
| Outpatient Mental Health Services (includes virtual behavioral health visits) | $10 copay after deductible | 30% after deductible |
| Outpatient Substance Abuse Services | $10 copay after deductible | 30% after deductible |
| Other Services |
| Acupuncture | $10 copay after deductible | not covered |
| 6 visits/plan year |
| Allergy Extracts | $0 after deductible | 30% after deductible |
| Allergy Injections | $10 copay after deductible | 30% after deductible |
| Applied Behavior Analysis for Autism Spectrum Disorder | $10 copay after deductible | 30% after deductible |
| limit: 680 hours/benefit period |
| **Assisted Fertilization Procedures** (GIFT & ZIFT excluded) | See service category (i.e. lab, surgery, imaging) | See service category (i.e. lab, surgery, imaging) |
| limit: 3 cycles/lifetime for in vitro fertilization |
| Dental Services Related to Accidental Injury | See service category (i.e. lab, surgery, imaging) | See service category (i.e. lab, surgery, imaging) |
| **Diagnostic Services** | $10 copay after deductible | 30% after deductible |
| Advanced Imaging (MRI, CAT, PET scan, etc.) |
| Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing) | $10 copay after deductible | 30% after deductible |
| Durable Medical Equipment and Supplies | $0 after deductible;$10 copay per item after deductible for diabetic equipment and supplies | 50% after deductible; 30% after deductible for diabetic equipment and supplies |
| Massage Therapy | $10 copay after deductible | not covered |
| 12 visits/plan year |
| Orthotics | 50% after deductible | not covered |
| Prosthetic Devices | $0 after deductible; 50% after deductible for external prosthetics | 30% after deductible |
| Home Health Care | $10 copay after deductible | 30% after deductible |
| limit: 200 visits/benefit period aggregate with visiting nurse and home infusion therapy |
| Hospice | $10 copay for outpatient services after deductible | 30% after deductible |
| limit: 210 days/benefit period |
| Infertility Counseling, Testing and Treatment | See service category (i.e. lab, surgery, imaging) | See service category (i.e. lab, surgery, imaging) |
| Skilled Nursing Facility Care | $0 after deductible | 30% after deductible |
| limit: 50 days/benefit period |
| Transplant Services | $0 after deductible | 30% after deductible |
| Prescription Drugs |
| Prescription Drug Deductible |  |
| Individual | Integrated with medical deductible |
| Family | Integrated with medical deductible |
| Prescription Drug Program (5)Defined by the National Plus NY 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 | **Retail Drugs (30/60/90-day Supply)**$5 / $10 / $15 Formulary generic copay after in-network deductible$20 / $40 / $60 Formulary brand copay after in-network deductible$40 / $80 / $120 Non-Formulary generic copay after in-network deductible$40 / $80 / $120 Non-Formulary brand copay after in-network deductible**Select Specialty Drugs (31-day Supply)**$5 Formulary generic copay after in-network deductible$20 Formulary brand copay after in-network deductible$40 Non-Formulary copay after in-network deductible**Maintenance Drugs through Mail Order (30/60/90-day Supply)**$5 / $10 / $15 Formulary generic copay after in-network deductible$20 / $40 / $60 Formulary brand copay after in-network deductible$40 / $80 / $120 Non-Formulary generic copay after in-network deductible$40 / $80 / $120 Non-Formulary brand copay after in-network deductible |

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. This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA).

1. Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
2. If you are enrolled in a "Family" plan, with your non-embedded deductible, the entire family deductible must be satisfied before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family out-of-pocket maximum amount is met.
3. Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider.
4. Services are limited to those listed on the Highmark NY Preventive Schedule (Women's Health Preventive Schedule may apply).
5. At a retail or mail-order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled. 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. Your plan requires that you use Accredo specialty pharmacy for select specialty medications.

Highmark Blue Cross Blue Shield of Western New York is a trade name of Highmark Western and Northeastern New York Inc., which is an independent licensee of the Blue Cross Blue Shield Association.

