# LCIC Loyalsock Twp PPO Blue Plan C 10212993, 10212994, 10212995
# Effective: 7-1-2025

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** | | |
| Benefit Period(1) | Calendar Year | |
| Deductible (per benefit period)<br>Individual<br>Family | <br>none<br>none | <br>$200<br>$600 |
| Plan Pays – payment based on the plan allowance | 100% | 80% after deductible |
| Out-of-Pocket Limit ( Once met, plan pays 100% coinsurance for the rest of the benefit period)<br>Individual<br>Family | <br>none<br>none | <br>$2,000<br>$6,000 |
| 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>$9,200<br>$18,400 | <br>not applicable<br>not applicable |
| **Office/Clinic/Urgent Care Visits** | | |
| Retail Clinic Visits & Virtual Visits | 100% after $10 copay | 80% after deductible |
| Primary Care Provider Office Visits & Virtual Visits | 100% after $10 copay | 80% after deductible |
| Specialist Office Visits & Virtual Visits | 100% after $20 copay | 80% after deductible |
| Virtual Visit Originating Site Fee | 100% | 80% after deductible |
| Urgent Care Center Visits | 100% after $20 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 $5 copay | not covered |
| **Preventive Care (4)** | | |
| **Routine Adult**<br>Physical Exams | <br>100% | <br>80% after deductible |
| Adult Immunizations | 100% | 80% after deductible |
| Routine Gynecological Exams, including a Pap Test | 100% | 80% (deductible does not apply) |
| Breast Cancer Screenings (annual routine and supplemental) | 100% | 80% after deductible |
| BRCA-Related Genetic Counseling and Genetic Testing | 100% | 80% after deductible |
| Colorectal Cancer Screening | 100% | 80% after deductible |
| Diagnostic Services and Procedures | 100% | 80% after deductible |
| **Routine Pediatric**<br>Physical Exams | <br>100% | <br>80% after deductible |
| Pediatric Immunizations | 100% | 80% (deductible does not apply) |
| Diagnostic Services and Procedures | 100% | 80% after deductible |
| **Emergency Services** | | |
| Emergency Room Services (5) | 100% after $50 copay (waived if admitted) | |
| Ambulance (includes coverage for wheelchair van transports) (6) | 100% | 100% (deductible does not apply) for emergencies; 80% after deductible for non-emergencies |
| **Hospital and Medical / Surgical Expenses (including maternity)** | | |
| Hospital Inpatient | 100% | 80% after deductible |
| Hospital Outpatient | 100% | 80% after deductible |
| Outpatient Surgery (facility) | 100% | 80% after deductible |
| Surgical Services (professional) | 100% | 80% after deductible |
| Maternity (non-preventive facility & professional services) including dependent daughter | 100% | 80% after deductible |

| Benefit | In Network | Out of Network |
|---|---|---|
| Medical Care (including inpatient visits and consultations)/Surgical Expenses | 100% | 80% after deductible |
| **Therapy and Rehabilitation Services** | | |
| Physical Medicine | 100% after $20 copay | 80% after deductible |
| | 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 | |
| Respiratory Therapy | 100% | 80% after deductible |
| Speech Therapy | 100% after $20 copay | 80% after deductible |
| | 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 | |
| Occupational Therapy | 100% after $20 copay | 80% after deductible |
| | 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 | |
| Spinal Manipulations | 100% after $20 copay | 80% after deductible |
| | limit: 12 visits/benefit period | |
| Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) | 100% | 80% after deductible |
| **Mental Health / Substance Abuse** | | |
| Inpatient Mental Health Services | 100% | 80% after deductible |
| Inpatient Detoxification / Rehabilitation | 100% | 80% after deductible |
| Outpatient Mental Health Services (includes virtual behavioral health visits) | 100% | 80% after deductible |
| Outpatient Substance Abuse Services | 100% | 80% after deductible |
| **Other Services** | | |
| Allergy Extracts and Injections | 100% | 80% after deductible |
| Autism Spectrum Disorder Including Applied Behavior Analysis (7) | 100% | 80% after deductible |
| | Limit: $40,000 annual maximum | |
| Assisted Fertilization | not covered | not covered |
| Dental Services Related to Accidental Injury | 100% | 80% after deductible |
| **Diabetes Treatment** Equipment and Supplies | 100% | 80% after deductible |
| Diabetes Education Program | 100% | 80% 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 $75 copay | 80% after deductible |
| | Copayments, if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse | |
| Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing) | 100% | 80% after deductible |
| Durable Medical Equipment Orthotics and Prosthetics | 100% | 80% after deductible |
| Home Health Care | 100% after $20 copay | 80% after deductible |
| Hospice | 100% | 80% 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 | |
| Infertility Counseling, Testing and Treatment (8) | 100% | 80% after deductible |
| Mammograms, Medically Necessary | 100% | 80% after deductible |
| Private Duty Nursing | not covered | not covered |
| Skilled Nursing Facility Care | 100% | 80% after deductible |
| | limit: 60 days/benefit period | |
| Transplant Services | 100% | 80% after deductible |
| Precertification Requirements (9) | Yes | Yes |
| **Prescription Drugs** | | |

| Benefit | In Network | Out of Network |
|---|---|---|
| Prescription Drug Deductible<br>Individual<br>Family | <br>none<br>none | |
| Prescription Drug Program (10)<br>SensibleRx Complete<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 | **Retail Drugs (30-day Supply)**<br>$3 low cost generic copay<br>$3 formulary low cost generic copay<br>$3 non-formulary low cost generic copay<br>$10 formulary generic copay<br>$10 non-formulary generic copay<br>$20 formulary brand copay<br>$35 non-formulary brand copay<br><br>**Maintenance Drugs through Mail Order (90-day Supply)**<br>$6 low cost generic copay<br>$6 formulary low cost generic copay<br>$6 non-formulary low cost generic copay<br>$20 formulary generic copay<br>$20 non-formulary generic copay<br>$40 formulary brand copay<br>$70 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.
(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) 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.
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. 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. This program utilizes the Copay Armor Plus drug list. 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.

**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）。

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).

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 Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht 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 المعاونة 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).

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក (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 yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

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

توجہ 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 మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दिनुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुनुहुन्छ। तपाईंको 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).