Cornwall Lebanon SD Choice Blue HDHP Benefit Summary

Group Number: 105276-63; 106217-44, -48

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). 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, 2023		
Benefit Period (1)	Calendar Year		
Deductible (Non-embedded; per benefit period) (All in-network services are credited to both enhanced and standard deductibles.) Individual Family	 $2,000 $4,000	 $3,000 $6,000	 $4,000 $8,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible	80% after deductible
Out-of-Pocket Limit (Non-embedded; Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 $50 $100	 $6,350 $12,700
Total Maximum Out-of-Pocket (Embedded; 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	 $6,350 $12,700		 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	$25 copay after deductible, then 100%	$25 copay after deductible, then 80%	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	$25 copay after deductible, then 100%	$25 copay after deductible, then 80%	80% after deductible
Specialist Office Visits & Virtual Visits	$40 copay after deductible, then 100%	$40 copay after deductible, then 80%	80% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible	80% after deductible
Urgent Care Center Visits	100% after deductible	80% after deductible	80% after deductible
Telemedicine Services (3)	100% after enhanced in-network deductible		Not covered
Preventive Care (4)			
Routine Adult Physical Exams	 100% (deductible does not apply)		 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
Mammograms, Medically Necessary	100% after enhanced in-network deductible		80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)		80% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)		 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 enhanced in-network deductible		

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
Ambulance – Emergency (6)	100% after enhanced in-network deductible		
Ambulance – Non-Emergency (6)	100% after enhanced in-network deductible		80% after deductible
Hospital and Medical / Surgical Expenses (including maternity)			
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 facility & professional services) including dependent daughter	100% after deductible	80% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	80% after deductible	80% after deductible
Therapy and Rehabilitation Services			
Physical Medicine	100% after deductible	80% after deductible	80% after deductible
	limit: 30 visits/benefit period including rehabilitative and habilitative services		
Respiratory Therapy	100% after deductible	80% after deductible	80% after deductible
Speech Therapy	$40 copay after deductible	$40 copay after deductible	80% after deductible
	limit: 12 visits/benefit period including rehabilitative and habilitative services		
Occupational Therapy	$40 copay after deductible	$40 copay after deductible	80% after deductible
	limit: 12 visits/benefit period including rehabilitative and habilitative services		
Spinal Manipulations	100% after deductible	80% after deductible	80% after deductible
	limit: 20 visits/benefit period including rehabilitative and habilitative services		
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)	$40 copay after enhanced in-network deductible, then 100%		80% after deductible
Outpatient Substance Abuse Services	$40 copay after enhanced in-network deductible, then 100%		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		
Dental Services Related to Accidental Injury	Not covered		
Diagnostic Services 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
Durable Medical Equipment and Orthotics	100% after deductible	80% after deductible	80% after deductible
Prosthetics	100% after deductible	100% after deductible	100% after deductible
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
Routine Cost Associated with Approved Clinical Trials	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		
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
Wigs	100% after deductible	100% after deductible	100% after deductible
	limit: $300 lifetime benefit maximum		
Precertification Requirements (9)	Yes		

Prescription Drugs	
Prescription Drug Deductible Individual Family	 Integrated with medical deductible Integrated with medical deductible
Contraceptives	$0 Copay – Retail or Mail Order
Prescription Drug Program (10) Hard Mandatory Generic Defined by the National 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)** $10 / $20 / $30 Generic copay after enhanced in-network deductible $35 / $70 / $105 Formulary brand copay after enhanced in-network deductible $50 / $100 / $150 Non-Formulary brand copay after enhanced in-network deductible **Maintenance Drugs through Mail Order (90-day Supply)** $20 Generic copay after enhanced in-network deductible $70 Formulary brand copay after enhanced in-network deductible $100 Non-Formulary brand copay after enhanced 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.

*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. If you are enrolled in a "Family" plan, with your non-embedded deductible, the entire family deductible must be satisfied before claims reimbursement begins. In addition, with your non-embedded out-of-pocket limit, the entire family out-of-pocket limit must be satisfied before additional claims reimbursement begins. Finally, with your embedded TMOOP, once any eligible family member satisfies his/her individual TMOOP, 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 TMOOP amount is met.

(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) 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) Services for the treatment of Autism Spectrum Disorders are covered for eligible members to age 21. 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) 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. Under the hard-mandatory generic provision, 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 to obtain select specialty medications. To obtain medications for hemophilia, you must use a specific pharmacy, please contact member services for more details.

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 हुनुछन्। तपाईको 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).