

## Pleasant Valley SD 10213483, 10433882, 10433883

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
<b>General Provisions</b>		
Effective	January 1, 2021	
Benefit Period(1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$250	\$1,000
Family	\$500	\$2,000
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Out-of-Pocket Limit ( Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	\$500	\$2,000
Family	\$1,000	\$4,000
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.		
Individual	\$8,550	not applicable
Family	\$17,100	not applicable
<b>Office/Clinic/Urgent Care Visits</b>		
Retail Clinic Visits & Virtual Visits	100% after \$20 copay	70% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$20 copay	70% after deductible
Specialist Office Visits & Virtual Visits	100% after \$25 copay	70% after deductible
Virtual Visit Originating Site Fee	90% after deductible	70% after deductible
Urgent Care Center Visits	100% after \$50 copay	70% after deductible
Telemedicine Services (3)	100% (deductible does not apply)	not covered
<b>Preventive Care (4)</b>		
<b>Routine Adult</b>		
Physical Exams	100% (deductible does not apply)	70% after deductible
Adult Immunizations	100% (deductible does not apply)	70% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, Medically Necessary	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Nutritional Therapy	100% (deductible does not apply)	70% after deductible
	Limit: 6 visits per benefit period. Covered for any diagnosis	
Prostate Cancer Screening	100% (deductible does not apply)	70% (deductible does not apply)
<b>Routine Pediatric</b>		
Physical Exams	100% (deductible does not apply)	70% after deductible
Pediatric Immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
<b>Emergency Services</b>		
Emergency Room Services	100% after \$100 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency	80% (deductible does not apply) for emergencies; 80% after deductible for non-emergencies	80% (deductible does not apply) for emergencies; 80% after deductible for non-emergencies
<b>Hospital and Medical / Surgical Expenses (including maternity)</b>		
Hospital Inpatient	90% after deductible	70% after deductible
Hospital Outpatient	90% after deductible	70% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	90% after deductible	70% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	90% after deductible	70% after deductible

Benefit	In Network	Out of Network
<b>Therapy and Rehabilitation Services</b>		
Physical Medicine	90% after deductible limit: 36 visits/benefit period aggregate with	70% after deductible speech therapy and occupational therapy
Respiratory Therapy	90% after deductible	70% after deductible
Speech Therapy	90% after deductible limit: 36 visits/benefit period aggregate with	70% after deductible occupational therapy and physical medicine
Occupational Therapy	90% after deductible limit: 36 visits/benefit period aggregate with	70% after deductible speech therapy and physical medicine
Spinal Manipulations	90% after deductible. \$25 copay applies to office visits only. limit: 18 visits/benefit period	70% after deductible
Cardiac Rehabilitation Therapy	90% after deductible limit: 36 visits/benefit period	70% after deductible
Infusion Therapy	90% after deductible	70% after deductible
Chemotherapy	90% after deductible	70% after deductible
Radiation Therapy	90% after deductible	70% after deductible
Dialysis	90% after deductible	70% after deductible
<b>Mental Health / Substance Abuse</b>		
Inpatient Mental Health Services	90% after deductible	70% after deductible
Inpatient Substance Abuse Detoxification	90% after deductible	70% after deductible
Inpatient Substance Abuse Rehabilitation	90% after deductible limit: 45 days/benefit period	70% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	90% after deductible	70% after deductible
Outpatient Substance Abuse Services	90% after deductible	70% after deductible
<b>Other Services</b>		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	not covered	not covered
Dental Services Related to Accidental Injury	not covered	not covered
<b>Diagnostic Services</b>		
Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Durable Medical Equipment, Orthotics, Prosthetics, and Ostomy Supplies	90% after deductible limit: \$5,000/benefit period	70% after deductible
Home Health Care	90% after deductible	70% after deductible
Hospice	90% after deductible limit: 180 days/ lifetime and respite care maximum of 5 days for every 3 months	70% after deductible
Infertility Counseling, Testing and Treatment	90% after deductible Testing to determine infertility only	70% after deductible
Private Duty Nursing	90% after deductible limit: 240 hours/benefit period	70% after deductible
Skilled Nursing Facility Care	90% after deductible limit: 100 days/benefit period	70% after deductible
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements (5)	Yes	Yes
<b>Prescription Drugs</b>		
Prescription Drug Deductible		
Individual		none
Family		none

Benefit	In Network	Out of Network
<p>Prescription Drug Program (6) Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</p> <p>Your plan uses the Comprehensive Formulary with an Open Benefit Design</p>	<p style="text-align: center;"><b>Retail Drugs (34-day Supply)</b> Plan Pays 80% \$20 minimum/\$40 maximum drug copay per prescription</p> <p style="text-align: center;"><b>Maintenance Drugs through Mail Order (90-day Supply)</b> Plan Pays 80% \$40 minimum/\$80 maximum drug copay per prescription</p>	

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/Substance Abuse benefit

(4) Services are limited to those listed on the Highmark Preventive Schedule with enhancements (Women's Health Preventive Schedule may apply).

(5) Be sure your provider is aware that Highmark Utilization Management must be contacted for authorization prior to a planned inpatient admission or within 48 hours of an emergency or unplanned inpatient admission. Also note that certain outpatient procedures require prior authorization. If authorization 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.

(6) 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. This formulary covers all FDA-approved generic and brand-name drugs. Under the soft 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, unless your doctor requests that the brand drug be dispensed. 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 schwetscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deine 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).

પ્રબલકારકો: 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)।

**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 yáńílti'go, language assistance services, éí t'áá níf'eh, bee níká a'doowól, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'déé' (TTY: 711) jí' hodíílnih.

ધ્યાન દે: यदि आप हनिदी 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).

توجه 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, లాగివేక అసనబినన సరవీసన, ఛార్జి తికండా, మేకు అందుబాటులో ఉననాయె. మే మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉనన నంబరుకు కాల్ చేయండి (TTY: 711).

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

ध्यान दनिहोस: यदि तिपाई नेपाली भाषा बोलनुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। 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).