State College Area School District
Groups: 02554125, 30, 33, 41, 42, 46, 48, 75, 78, 82, 84, 89, 97, 98

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. 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	01/01/2027	
Benefit Period (1)	Contract Year Begins January 1 and Ends December 31	
Deductible (per benefit period) Individual Family	 $1,750 $3,500	 $3,500 $7,000
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible
Out-of-Pocket Limit (Includes any medical and prescription drug coinsurance and copays) Once met, the plan pays 100% coinsurance for the rest of the benefit period. Individual Family	 $1,750 $3,500	 $3,500 $7,000
Total Maximum Out-of-Pocket (Includes any medical and prescription drug deductibles, coinsurance, and copays, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $3,500 $7,000	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	$25 copay after deductible, 100% thereafter	70% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	$25 copay after deductible, 100% thereafter	70% after deductible
Specialist Office Visits & Virtual Visits	$25 copay after deductible, 100% thereafter	70% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	70% after deductible
Urgent Care Center Visits	$50 copay after deductible, 100% thereafter	70% after deductible
On-Demand Telemedicine Services (3)	100% after deductible	not covered
Preventive Care (4)		
Routine Adult		
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)
Breast Cancer Screenings	100% (deductible does not apply)	70% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	70% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	70% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Routine Pediatric		
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
Emergency Services		
Emergency Room Services (5)	$100 copay (waived if admitted) after deductible, 100% thereafter	

Benefit	In Network	Out of Network
Ambulance - Emergency and Non-Emergency (6)	100% after deductible	100% after in-network deductible for emergencies; 70% after out-of-network deductible for non-emergencies
Hospital and Medical / Surgical Expenses (5)		
Hospital Inpatient (including maternity)	100% after deductible	70% after deductible
Hospital Outpatient	100% after deductible	70% after deductible
Outpatient Surgery (facility)	100% after deductible	70% after deductible
Surgical Services (professional)	100% after deductible	70% after deductible
Maternity (non-preventive professional services) including dependent daughter	100% after deductible	70% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	70% after deductible
Therapy Services		
Physical Medicine	$25 copay after deductible, 100% thereafter	70% after deductible
	limit: 30 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Speech Therapy	$25 copay after deductible, 100% thereafter	70% after deductible
	limit: 30 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Occupational Therapy	$25 copay after deductible, 100% thereafter	70% after deductible
	limit: 30 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	
Respiratory Therapy	100% after deductible	70% after deductible
Spinal Manipulations	$25 copay after deductible, 100% thereafter	70% after deductible
	limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	70% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	70% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	$25 copay after deductible, 100% thereafter	70% after deductible
Outpatient Substance Abuse Services	$25 copay after deductible, 100% thereafter	70% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	70% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	$25 copay after deductible, 100% thereafter	70% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury (10)	not covered	
Diabetes Treatment		
Equipment and Supplies	100% after deductible	70% after deductible
Diabetes Education Program	100% after deductible	70% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	70% after deductible
Mammograms, Medically Necessary	100% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	70% after deductible
Enteral Foods	100% after deductible	70% after deductible
Home Health Care	100% after deductible	70% after deductible
	limit: 90 visits/benefit period aggregate with visiting nurse	
Home Infusion and Suite Infusion Therapy	100% after deductible	70% after deductible
Hospice	100% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment (8) (10)	100% after deductible	70% after deductible
Private Duty Nursing	100% after deductible	70% after deductible

Benefit	In Network	Out of Network
	limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after deductible	70% after deductible
	limit: 100 days/benefit period	
Therapeutic Injections	100% after deductible	70% after deductible
Transplant Services (10)	100% after deductible	70% after deductible
Precertification/Authorization Requirements (9)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	 Integrated with medical deductible Integrated with medical deductible	
Prescription Drug Program (11) SensibleRx Choice 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	**Retail Drugs (31/60/90-day Supply)** 10% for Formulary generic drugs after in-network deductible 10% for Non-Formulary generic drugs after in-network deductible 25% for Formulary brand drugs after in-network deductible 30% for Non-Formulary brand drugs after in-network deductible **Select Specialty Drugs (31-day Supply)** $3 Formulary generic drug Specialty copay after in-network deductible $3 Non-Formulary generic drug Specialty copay after in-network deductible $10 Formulary brand drug Specialty copay after in-network deductible $16 Non-Formulary brand drug Specialty copay after in-network deductible **Maintenance Drugs through Mail Order (90-day Supply)** $10 Formulary generic copay after in-network deductible $10 Non-Formulary generic copay after in-network deductible $30 Formulary brand copay after in-network deductible $50 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.

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include any medical and prescription drug deductibles, coinsurance, and copays. 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 non-embedded out-of-pocket limit, the entire family out-of-pocket limit must be satisfied before additional claims reimbursement begins. With your non-embedded TMOOP, once the entire family TMOOP is satisfied, claims will pay at 100% of the plan allowance for covered expenses for the family, for the rest of the plan year.

(3) On-Demand 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. PCP is eligible under the PCP Office Visit benefit, 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) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist, or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant, or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services-Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders 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). Services for the treatment of Autism Spectrum Disorders do 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) Covered Services will be covered according to the benefit category to which they apply (e.g. outpatient surgery, hospital inpatient, diagnostic services).
(11) 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 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 Choice, when you purchase certain brand drugs that have generic equivalents, you will be responsible for the brand drug member cost share indicated plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed. Your plan requires that you use Accredo specialty pharmacy for select specialty medications.

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An Independent Licensee of the Blue Cross and Blue Shield Association

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 of Civil Rights Complaint Portal, available at 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
Phone: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html

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ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

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ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

ÀKÍYÈSÍ: Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati òǵbufọ èdè wà ní àrọwọtó lọ́fẹ̀ẹ́ fún ọ. Awọn iṣẹ ìtǫ́jú ati ìràànlọ́wọ́ tó yẹ (bíi titẹwé nla, gbigbọ ohùn, ati ìwé afọ́jú) lati pèsè iwifúnni ni awọn ọna ìrááyè si wà pẹlu lọ́fẹ̀ẹ́. Pe nọmba tó wà lẹhin kaádì ìdánimọ rẹ (TTY: 711) fún iràànlọwọ.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזויווי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל (TTY: 711) פאר הילף.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقاتٍ يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدوّن على ظهر بطاقة هويتك (TTY: 711) للحصول على المساعدة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字体、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的 ID 卡背面的号码（听障人士专用号码： 711）。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિઃશુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેઇલ) પણ નિઃશુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઇડી કાર્ડની પાછળ આપેલા નંબર (TTY: 711) પર કૉલ કરો.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि निःशुल्क उपलब्ध छन्। मद्दतको लागि तपाईंको ID कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ़्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फ़ॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी निःशुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

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