Plan Types	FCE Standard		USW w/ Plan A	USW v FCE	
Major Medical Benefits	**Current**	**2022**	**PPO 80/50**	**Current**	**2022**
Annual In-network deductible (Ind/Fam)	$6,350/$12,700	$6,350/$12,700	**$5,000 / $10,000**	**USW $1,350/$2,700 less**	**USW $1,350/$2,700 less**
Out-of-pocket maximum (Ind/Fam)	$8,150 /$16,300	$8,150 /$16,300	$1,500/$3,000 (not inc. co-pay/ins) **$6,850/$13,700 Total OOPM**	**USW Total Max OOP is $1,300/ $2,600 less**	**USW Total Max OOP is $1,300/ $2,600 less**
Coinsurance	40% after ded	40% after ded	20% after ded	**USW 20% less**	**USW 20% less**
Office visits	40% after ded	**$30**	20% after ded	**USW 20% less**	**FCE $30**
Specialist visits	40% after ded	**$60**	20% after ded	**USW 20% less**	**FCE $60**
Preventative services	100% no ded	100% no ded	100% no ded	Even	Even
Diagnostic X-rays and lab tests	40% after ded	40% after ded	20% after ded	**USW 20% less**	**USW 20% less**
Inpatient care	40% after ded	40% after ded	20% after ded	**USW 20% less**	**USW 20% less**
Outpatient care	40% after ded	40% after ded	20% after ded	**USW 20% less**	**USW 20% less**
Emergency room services	40% after ded	40% after ded	20% after ded	**USW 20% less**	**USW 20% less**
Urgent care	40% after ded	40% after ded	20% after ded	**USW 20% less**	**USW 20% less**
Retail Prescription Drugs					
In network; 30 days - FCE/ 34 days - USW	$10	$10	$10	Even	Even
Generic drugs Formulary brand name	30% after ded	**$30**	$20	**USW**	**USW $10 less**
Non-formulary brand name and specialty drugs	30% after ded	**$60**	$20	**USW**	**USW $50 less**
Mail Order Prescription Drugs					
(up to 90 days) In network	$20	$20	$20	Even	Even
Generic drugs Formulary brand name	30% after ded	**$60**	$40	**USW**	**USW $20 less**
Non-formulary brand name and specialty drugs	30% after ded	**$120**	$40	**USW**	**USW $100 less**
Monthly Premium Rates	**No Longer offered**	**6% increase New default plan**		**Premium Difference**	**Premium Difference**
EE	$492.25	$521.79	$503.38	**(11.13)**	**18.41**
EE + Sp	$1,172.27	$1,242.61	$1,218.19	**(45.92)**	**24.42**
EE + Ch(ren)	$966.63	$1024.63	$1,122.55	**(155.92)**	**(97.92)**
Family	$1,583.51	$1,678.52	$1,595.74	**(12.23)**	**82.78**
PER CHECK Premium Rates				**$ change**	**$ change**
EE	$227.19	$240.83	$232.33	**(5.14)**	**8.50**
EE + Sp	$541.05	$573.51	$562.24	**(21.19)**	**11.27**
EE + Ch(ren)	$446.14	$472.91	$518.10	**(71.96)**	**(45.19)**
Family	$730.85	$774.70	$736.50	**(5.64)**	**38.21**

Summary of PPO *Benefits*

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period.

Benefit	In-Network	Out-of-Network
Benefit Period①	Calendar Year	
Deductible (per benefit period) Individual Family	 $5,000 $10,000	 $5,000 $10,000
Plan Payment Level – Based on the provider's reasonable charge (PRC)	80% after deductible until out-of-pocket limit is met, then 100%	50% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limit (per benefit period)④ Individual Family	 $1,500 $3,000	 $5,000 $10,000
Total Maximum Out-of-Pocket⑤ (per benefit period) Individual Family	 $6,850 $13,700	 N/A N/A
Lifetime Maximum (per person)	Unlimited	Unlimited
Physician Office Visits	80% after deductible	50% after deductible
Specialist Office Visits	80% after deductible	50% after deductible
Urgent Care Center Visits	80% after deductible	50% after deductible
Telemedicine Services⑨	100% after $0 copayment	Not Covered
Preventive Care⑦ ***Adult*** Routine Physical exams	 100% (deductible/copayment does not apply)	 Not Covered
Adult Immunizations	100% (deductible does not apply)	50% after deductible
Routine gynecological exams, including a PAP Test	100% (deductible/copayment does not apply)	50% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	50% after deductible
Well-Women Care⑧	100% (deductible does not apply)	50% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Pediatric Routine physical exams	 100% (deductible/copayment does not apply)	 Not Covered
Pediatric immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Emergency Room Services	80% after deductible	
Spinal Manipulations	80% after deductible	50% after deductible
	Limit: 20 visits/calendar year	
Physical Medicine and Speech and Occupational Therapy	80% after deductible	50% after deductible
Ambulance	80% after deductible	
Applied Behavior Analysis for Autism Spectrum Disorders (ASD)⑥	80% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	80% after deductible	50% after deductible
Diabetes Treatment	80% after deductible	50% after deductible
Diagnostic Services ***Advanced Imaging*** (MRI, CAT Scan, PET scan, etc.)	80% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	50% after deductible

Benefit	In-Network	Out-of-Network
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	
Enteral Foods	80% (deductible does not apply)	50% (deductible does not apply)
Home Infusion Therapy	80% after deductible	
Home Health Care	80% after deductible	
Hospice	80% after deductible	
Hospital Services – Inpatient	80% after deductible	50% after deductible
Hospital Services – Outpatient	80% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment②	80% after deductible	50% after deductible
Maternity (facility & professional services)	80% after deductible	50% after deductible
Medical/Surgical Expenses (Except Office Visits)	80% after deductible	50% after deductible
Mental Health – Inpatient	80% after deductible	50% after deductible
Mental Health – Outpatient	80% after deductible	50% after deductible
Pediatric Extended Care Services	80% after deductible	50% after deductible
	Limit: 100 days/calendar year	
Private Duty Nursing	80% after deductible	
Respiratory Therapy	80% after deductible	
Skilled Nursing Facility Care	80% after deductible	
Substance Abuse – Inpatient Detoxification	80% after deductible	50% after deductible
Substance Abuse – Inpatient Rehabilitation	80% after deductible	50% after deductible
Substance Abuse – Outpatient	80% after deductible	50% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	50% after deductible
Transplant Services	80% after deductible	50% after deductible
Precertification Requirements	Performed by Member③	

For Providers in your area call 1-800-810-BLUE

① Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

② Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy is covered.

③ Highmark Healthcare Management (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

④ Out-of-pocket limits do not include copayments, deductibles, prescription drug cost share, or amounts in excess of the Allowable Charge. Once the out-of-pocket limit is met, the plan will pay 100% for the remainder of the benefit period for benefits subject to coinsurance.

⑤ Total maximum out-of-pocket includes copayments, deductibles, prescription drug cost share and out-of-pocket limits. Once the total maximum out-of-pocket is met, the plan will pay 100% for the remainder of the benefit period. This amount is subject to change per ACA guidelines.

⑥ Coverage for eligible members to age 21. Services will be paid according to the benefit category, i.e., speech therapy. Treatment for autism spectrum disorders does not reduce visit/day limits.

⑦ Services are limited to those listed on the Highmark Preventive Schedule and the Women's Health Preventive Schedule. Gender, age and frequency limits may apply.

⑧ Benefits are provided for female members for items and services, including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods (In-Network coverage only) and counseling and breastfeeding support and counseling.

⑨ 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.

Benefit	In-Network		Out-of-Network
National Plus Prescription Drug Program (Defined by National Plus Pharmacy Network - Not Physician Network)	Retail – 34-day supply Mail Order – 90 day supply Mandatory Generic①		Not Covered
Option A	Retail ➢ $10 copayment generic ➢ $20 copayment brand	Mail-Order ➢ $20 copayment generic ➢ $40 copayment brand	
Option B	Retail ➢ $15 copayment generic ➢ $40 copayment brand	Mail Order ➢ $30 copayment generic ➢ $80 copayment brand	
Option C	Retail ➢ $20 copayment generic ➢ $50 copayment brand	Mail Order ➢ $40 copayment generic ➢ $100 copayment brand	
Option D	Retail ➢ $10 copayment generic ➢ $20 copayment brand formulary② ➢ $35 copayment non-formulary	Mail Order ➢ $20 copayment generic ➢ $40 copayment brand formulary② ➢ $70 copayment non-formulary	
Option E	Retail ➢ $15 copayment generic ➢ $30 copayment brand formulary② ➢ $45 copayment non-formulary	Mail Order ➢ $30 copayment generic ➢ $60 copayment brand formulary② ➢ $90 copayment non-formulary	
Option F	Retail ➢ $20 copayment generic ➢ $40 copayment brand formulary② ➢ $80 copayment non-formulary	Mail Order ➢ $40 copayment generic ➢ $80 copayment brand formulary② ➢ $160 copayment non-formulary	

① The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand drug. The member payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or coinsurance amounts, which may apply.

② The formulary is an extensive list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above.