

# Intermediate Unit 1 Health Insurance Consortium Plan G (G)

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	Network	Out-of-Network
<b>General Provisions</b>		
<b>Benefit Period</b> (1)	Calendar Year	
<b>Deductible</b> (per benefit period)		
Individual	None	\$250
Family	None	\$500
<b>Plan Pays</b> – payment based on the plan allowance	100%	80% after deductible
<b>Out-of-Pocket Limit</b> (Once met, plan pays 100% for the rest of the benefit period)		
Individual	None	\$2,000
Family	None	\$4,000
<b>Autism Spectrum Disorders (ASD) Maximum (per person )(2)</b>	\$40,000/benefit period	
<b>Office/Clinic/Urgent Care Visits</b>		
<b>Retail Clinic Visits</b>	100% after \$10 copayment	80% after deductible
<b>Primary Care Provider Office Visits</b>	100% after \$10 copayment	80% after deductible
<b>Specialist Office Visits</b>	100% after \$10 copayment	80% after deductible
<b>Urgent Care Center Visits</b>	100% after \$10 copayment	80% after deductible
<b>Preventive Care</b> (3)		
<b>Routine Adult</b>		
Physical exams	100% after \$10 copayment	Not Covered
Adult immunizations	100%	80% after deductible
Colorectal cancer screening	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100% after \$10 copayment	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
<b>Routine Pediatric</b>		
Physical exams	100% after \$10 copayment	Not Covered
Pediatric immunizations	100%	80% (deductible does not apply)
Diagnostic services and procedures	100%	80% after deductible
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>		
<b>Hospital Inpatient</b>		
<b>Hospital Outpatient</b>		
<b>Maternity</b> (non-preventive facility & professional services)	100%	80% after deductible
<b>Medical/Surgical</b> (except office visits)		
<b>Emergency Services</b>		
<b>Emergency Room Services</b>	100% after \$25 copayment (waived if admitted)	
<b>Ambulance</b>	100%	
<b>Therapy and Rehabilitation Services</b>		
<b>Physical Medicine</b>	100% after \$10 copayment	80% after deductible Limit: 20 visits/benefit period
<b>Respiratory Therapy</b>	100%	
<b>Speech &amp; Occupational Therapy</b>	100% after \$10 copayment	80% after deductible Limit: 20 visits per therapy/benefit period
<b>Spinal Manipulations</b>	100% after \$10 copayment	80% after deductible Limit: 20 visits/benefit period
<b>Other Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
<b>Mental Health/Substance Abuse</b>		
<b>Inpatient</b>	100%	80% after deductible
<b>Inpatient Detoxification/Rehabilitation</b>		
<b>Outpatient</b>	100%	80% after deductible
<b>Other Services</b>		
<b>Allergy Extracts and Injections</b>		
<b>Applied Behavior Analysis for Autism Spectrum Disorders</b> (2)	100%	80% after deductible

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Dental Services Related to Accidental Injury</b>	100%	80% after deductible
<b>Diagnostic Services</b> <i>Advanced Imaging (MRI, CAT, PET scan, etc.)</i>	100%	80% after deductible
<i>Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</i>	100%	80% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100%	80% after deductible
<b>Home Health Care</b>		
<b>Hospice</b>		
<b>Infertility Counseling, Testing and Treatment (4)</b>		
<b>Private Duty Nursing</b>	100%	
<b>Skilled Nursing Facility Care</b>	100%	80% after deductible Limit: 100 days/benefit period
<b>Transplant Services</b>	100%	80% after deductible
<b>Precertification Requirements (5)</b>	Yes	
<b>Prescription Drugs</b>		
<b>Prescription Drug Deductible</b> Individual Family	None None	
<b>Prescription Drug Program (6)</b> <i>Defined by the Premier 2012 Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>  <i>Comprehensive Formulary</i>	<p style="text-align: center;"><b>Retail Drugs</b></p> <p style="text-align: center;">\$5 generic copayment \$15 brand copayment – formulary \$30 brand non-formulary Mandatory Generic 34 day supply</p> <p style="text-align: center;"><b>Maintenance Drugs through Mail Order (90-day Supply)</b></p> <p style="text-align: center;">\$10 generic copayment \$30 brand copayment – formulary \$60 brand copayment non-formulary 90 day supply</p>	

- (1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
- (2) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits. If ASD benefit period dollar maximum applies, only non-essential health benefits will accumulate.
- (3) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
- (4) 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.
- (5) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. 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.
- (6) The formulary is an extensive list of Food and 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. You are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.