

NFT Metro POS 200 - $20/$20 (0003) - 10663315, 23, 31

On the chart below, you'll see what you pay 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 | **JANUARY 1** | | |
| Benefit Period (1) | Calendar Year | | |
| Deductible (per benefit period) |  | |  |
| Individual | None | | $750 |
| Family | None | | $1,500 |
| Deductible Accumulation (2) | Not applicable | | Embedded |
| Coinsurance - payment based on the plan allowance | Not applicable | | 25% after deductible |
| **Out-of-Pocket Maximum**  (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses). Once met, the plan pays 100% of covered services for the rest of the benefit period. |  | |  |
| Individual | $3,000 | | $3,750 |
| Family | $6,000 | | $7,500 |
| Out-of-Pocket Accumulation (2) | Embedded | | Embedded |
| Office/Urgent Care Visits | | | |
| Primary Care Provider Office Visits & Virtual Visits | $20 copay | | 25% after deductible |
| Specialist Office Visits & Virtual Visits | $20 copay | | 25% after deductible |
| Virtual Visit Provider Originating Site Fee | covered in full | | 25% after deductible |
| Urgent Care Center Visits | $20 copay | | $20 copay |
| Telemedicine Services (3) | $20 copay | | not covered |
| Preventive Care (4) | | | |
| **Routine Adult** | covered in full | | not covered |
| Physical Exams |
| Adult Immunizations | covered in full | | 25% after deductible |
| Routine Gynecological Exams, including a Pap Test | covered in full | | 25% after deductible |
| Mammograms, Annual Routine | covered in full | | 25% after deductible |
| Mammograms, Medically Necessary | $20 copay | | 25% after deductible |
| Diagnostic Services and Procedures | covered in full | | 25% after deductible |
| **Routine Pediatric** | covered in full | | 25% after deductible |
| Physical Exams |
| Pediatric Immunizations | covered in full | | 25% after deductible |
| Diagnostic Services and Procedures | covered in full | | 25% after deductible |
| Emergency Services | | | |
| Emergency Room Services | $150 copay (waived if admitted);  $20 copay for freestanding urgent care facility | | |
| Ambulance - Emergency and Non-Emergency | $50 copay | | |
| Hospital and Medical / Surgical Expenses (including maternity) | | | |
| Hospital Inpatient | $250 inpatient copay/admission | | 25% after deductible |
| Outpatient Surgery | $20 copay | | 25% after deductible |
| Maternity (non-preventive professional services) including dependent daughter | $20 copay on initial visit only | | 25% after deductible |
| Medical Care (including inpatient visits and consultations) | covered in full | | 25% after deductible |
| Therapy and Rehabilitation Services | | | |
| Physical Therapy | $20 copay | | 25% after deductible |
| limit: 30 visits/benefit period | | |
| Respiratory Therapy | $20 copay | | 25% after deductible |
| limit: 24 visits/benefit period for pulmonary rehabilitation | | |
| Speech Therapy | $20 copay | | 25% after deductible |
| limit: 30 visits/benefit period | | |
| Occupational Therapy | $20 copay | | 25% after deductible |
| limit: 30 visits/benefit period | | |
| Spinal Manipulations | $20 copay | | 25% after deductible |
| Cardiac Rehabilitation Therapy | $20 copay | | 25% after deductible |
| limit: 24 visits/benefit period | | |
| Infusion Therapy | $20 copay;  covered in full for home infusion | | 25% after deductible |
| Chemotherapy | $20 copay | | 25% after deductible |
| Radiation Therapy | $20 copay | | 25% after deductible |
| Dialysis | $20 copay;  covered in full for home dialysis | | 25% after deductible |
| Mental Health / Substance Abuse | | | |
| Inpatient Mental Health Services | $250 inpatient copay/admission | | 25% after deductible |
| Inpatient Detoxification / Rehabilitation | $250 inpatient copay/admission | | 25% after deductible |
| Outpatient Mental Health Services  (includes virtual behavioral health visits) | $20 copay | | 25% after deductible |
| Outpatient Substance Abuse Services | $20 copay | | 25% after deductible |
| Other Services | | | |
| Acupuncture | $20 copay | | not covered |
| 6 visits/plan year | | |
| Allergy Extracts | covered in full | | 25% after deductible |
| Allergy Injections | $20 copay | | 25% after deductible |
| Applied Behavior Analysis for Autism Spectrum Disorder | $20 copay | | 25% after deductible |
| limit: 680 hours/benefit period | | |
| **Assisted Fertilization Procedures**  (GIFT & ZIFT excluded) | See service category (i.e. lab, surgery, imaging) | See service category (i.e. lab, surgery, imaging) | |
| limit: 3 cycles/lifetime for in vitro fertilization | | |
| Dental Services Related to Accidental Injury | See service category (i.e. lab, surgery, imaging) | See service category (i.e. lab, surgery, imaging) | |
| **Diagnostic Services** | $20 copay | | 25% after deductible |
| Advanced Imaging (MRI, CAT, PET scan, etc.) |
| Standard Imaging | $20 copay | | 25% after deductible |
| Diagnostic Medical | $20 copay | | 25% after deductible |
| Pathology/Laboratory | covered in full | | 25% after deductible |
| Allergy Testing | $20 copay | | 25% after deductible |
| Durable Medical Equipment and Supplies | 50%; $20 copay for diabetic supplies; $20 copay for diabetic equipment | | 50% after deductible;  25% after deductible for diabetic equipment and supplies |
| Massage Therapy | $20 copay | | not covered |
| 12 visits/plan year | | |
| Orthotics | 50% | | not covered |
| Prosthetic Devices | covered in full;  50% for external prosthetics | | 25% after deductible |
| Home Health Care | covered in full | | 25% after deductible |
| Hospice | covered in full | | 25% after deductible |
| limit: 210 days/benefit period | | |
| Infertility Counseling, Testing and Treatment | See service category (i.e. lab, surgery, imaging) | See service category (i.e. lab, surgery, imaging) | |
| Skilled Nursing Facility Care | $250 inpatient copay/admission | | 25% after deductible |
| Unlimited days | | |
| Transplant Services | $250 inpatient copay/admission (recipient) | | 25% after deductible |
| Prescription Drugs | | | |
| Prescription Drug Deductible |  | | |
| Individual | none | | |
| Family | none | | |
| Prescription Drug Program (5)  Defined by the National Plus NY 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 (30/60/90-day Supply)**  $5 / $10 / $15 Formulary generic copay  $20 / $40 / $60 Formulary brand copay  $35 / $70 / $105 Non-Formulary generic copay  $35 / $70 / $105 Non-Formulary brand copay  **Select Specialty Drugs (31-day Supply)**  $5 Formulary generic copay  $20 Formulary brand copay  $35 Non-Formulary copay  **Maintenance Drugs through Mail Order (30/60/90-day Supply)**  $5 / $5 / $5 Formulary generic copay  $20 / $20 / $20 Formulary brand copay  $35 / $70 / $105 Non-Formulary generic copay  $35 / $35 / $35 Non-Formulary brand copay | | |

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. If you are enrolled in a "Family" plan, with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. With your embedded out-of-pocket maximum, once any eligible family member satisfies his/her individual out-of-pocket maximum, 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 out-of-pocket maximum amount is met.
3. Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider.
4. Services are limited to those listed on the Highmark NY Preventive Schedule (Women's Health Preventive Schedule may apply).
5. 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. Your plan requires that you use Accredo specialty pharmacy for select specialty medications.

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