Manheim Township QHDHP 2000 PPO Benefit Summary

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	January 1, 2026	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 $2,000 $4,000	
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes coinsurance, copays and prescription drug cost sharing. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 $3,000 $6,000	 $6,000 $12,000
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 Family	 $5,000 $10,000	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	$20 copay after deductible, 100% thereafter	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	$20 copay after deductible, 100% thereafter	80% after deductible
Specialist Office Visits & Virtual Visits	$35 copay after deductible, 100% thereafter	80% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	$35 copay after deductible, 100% thereafter	80% after deductible
	copay, if any, does not apply to urgent care center visits prescribed for the treatment of mental health or substance abuse	
Telemedicine Services (3)	100% after deductible	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
PSA Testing (19 years and older)	100% (deductible does not apply)	80% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services (5)	$100 copay (waived if admitted) after deductible, 100% thereafter	
Ambulance - Emergency and Non-Emergency (6)	100% after in-network deductible	
Ambulance – Non-Emergency (6)	100% after deductible	80% after deductible
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive professional services)	100% after deductible	80% after deductible
Maternity for Dependent Daughters	not covered	not covered
Medical Care (including inpatient visits and consultations) – excludes sterilization reversal procedures	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	$35 copay after deductible, 100% thereafter	80% 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	$35 copay after deductible, 100% thereafter	80% 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	$35 copay after deductible, 100% thereafter	80% 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	

Benefit	In Network	Out of Network
Respiratory Therapy	100% after deductible	80% after deductible
Spinal Manipulations	$35 copay after deductible, 100% thereafter	80% after deductible
	limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	80% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	$35 copay after deductible, 100% thereafter	80% after deductible
Outpatient Substance Abuse Services	$35 copay after deductible, 100% thereafter	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	100% after deductible	80% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diabetes Treatment	100% after deductible	80% after deductible
Diagnostic Services	copays, if any, do not apply to diagnostic services prescribed for the treatment of mental health or substance abuse	
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Mammograms, Medically Necessary	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
	Cranial Wig - $200 maximum per lifetime due to hair loss from Chemo Therapy	
Home Health Care	100% after deductible	80% after deductible
	limit: 90 visits/benefit period	
Hospice	100% after deductible for respite care	80% after deductible for respite care
Infertility Counseling, Testing and Treatment (8)	100% after deductible	80% after deductible
Orthoptic Eye Vision Therapy/Exercises	$35 copay after deductible; 100% thereafter	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	limit: 60 days/benefit period	
Transplant Services	100% after deductible	80% 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 (10) 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)** $8 / $16 / $24 generic copay after in-network deductible $20 / $40 / $60 Formulary brand copay after in-network deductible $45 / $90 / $130 Non-Formulary brand copay after in-network deductible **Maintenance Drugs through Mail Order (90-day Supply)** $16 Formulary generic copay after in-network deductible $40 Formulary brand copay after in-network deductible $90 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 deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. If you are enrolled in a "Family" plan, with your non-embedded deductible, the entire family deductible must be satisfied before claims reimbursement begins. In addition, with your non-embedded out-of-pocket limit, the entire family out-of-pocket limit must be satisfied before additional claims reimbursement begins. Finally, with your embedded TMOOP, once any eligible family member satisfies his/her individual TMOOP, 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 TMOOP amount is met.

(3) 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 with Enhancements (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) After initial evaluation, Applied Behavioral Analysis 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). Treatment for Autism Spectrum Disorders does 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) 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 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. Under SensibleRx Choice, 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. Your plan requires that you use Accredo specialty pharmacy for select specialty medications.

Accepted by _____ Title _____ Date _____