

## Summary of Benefits

This Summary of Benefits is a brief description of covered services.

| Benefit  | Performance Blue PPO  |                                  | PPO Blue  |                                  |
|--|---|----------------------------------|---|----------------------------------|
|  | In-Network  | Out-of-Network                   | In-Network  | Out-of-Network                   |
| <b>General Provisions</b>  |   |                                  |   |                                  |
| <b>PLAN YEAR</b> <sup>(1)</sup>  | <b>CALENDAR YEAR</b>  |                                  |   |                                  |
| <b>Deductible</b> (per plan year)<br>Individual<br>Family  | \$800<br>\$1,600  | \$1,600<br>\$3,200               | \$2,000<br>\$4,000  | \$2,400<br>\$4,800               |
|  | If you and your spouse voluntarily complete the wellness requirements, the in-network deductible is <b>waived</b> . |                                  | If you and your spouse voluntarily complete the wellness requirements the in-network individual deductible will be reduced to \$1,200 and the family deductible will be reduced to \$2,400. |                                  |
| <b>Plan Pays</b> – payment based on the plan allowance   | 100% after deductible   | 80% after deductible             | 100% after deductible   | 80% after deductible             |
| <b>Out-of-Pocket Limit</b> (Once met, plan pays 100% coinsurance for the rest of the plan year)<br>Individual<br>Family  | None<br>None  | \$4,800<br>\$9,600               | None<br>None  | \$4,800<br>\$9,600               |
| <b>Total Maximum Out-of-Pocket</b> (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) <sup>(2)</sup> Once met, the plan pays 100% of covered services for the rest of the benefit period.<br>Individual<br>Family | \$8,150<br>\$16,300   | Not Applicable<br>Not Applicable | \$8,150<br>\$16,300   | Not Applicable<br>Not Applicable |
| <b>Office/Clinic/Urgent Care Visits</b>  |   |                                  |   |                                  |
| <b>Retail Clinic Visits &amp; Virtual Visits</b>   | 100% after \$15 copayment   | 80% after deductible             | 100% after \$15 copayment   | 80% after deductible             |
| <b>Primary Care Provider Office Visits &amp; Virtual Visits</b>  | 100% after \$15 copayment   | 80% after deductible             | 100% after \$15 copayment   | 80% after deductible             |
| <b>Specialist Office &amp; Virtual Visits</b>  | 100% after \$30 copayment   | 80% after deductible             | 100% after \$30 copayment   | 80% after deductible             |
| Virtual Visit Originating Site Fee   | 100% after deductible   | 80% after deductible             | 100% after deductible   | 80% after deductible             |
| <b>Urgent Care Center Visits</b> Copayment, if any, does not apply to Urgent Care visits prescribed for the treatment of Mental Health or Substance Abuse  | 100% after \$15 copayment   | 80% after deductible             | 100% after \$15 copayment   | 80% after deductible             |
| <b>Telemedicine</b> <sup>(3)</sup>   | 100% (deductible does not apply)  | Not Covered                      | 100% (deductible does not apply)  | Not Covered                      |
| <b>Preventive Care</b> <sup>(4)</sup>  |   |                                  |   |                                  |
| <b>Routine Adult</b>   |   |                                  |   |                                  |
| Physical exams   | 100% (deductible does not apply)  | 80% after deductible             | 100% (deductible does not apply)  | 80% after deductible             |
| Adult immunizations  | 100% (deductible does not apply)  | 80% after deductible             | 100% (deductible does not apply)  | 80% after deductible             |
| Colorectal cancer screening  | 100% (deductible does not apply)  | 80% after deductible             | 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)  | 100% (deductible does not apply)  | 80% (deductible does not apply)  |
| Mammograms, annual routine and medically necessary   | Routine and Medically Necessary: 100% (deductible does not apply)   | 80% after deductible             | Routine and Medically Necessary: 100% (deductible does not apply)   | 80% after deductible             |
| Diagnostic services and procedures   | 100% (deductible does not apply)  | 80% after deductible             | 100% (deductible does not apply)  | 80% after deductible             |
| <b>Routine Pediatric</b>   |   |                                  |   |                                  |
| Physical exams   | 100% (deductible does not apply)  | 80% after deductible             | 100% (deductible does not apply)  | 80% after deductible             |
| Pediatric immunizations  | 100% (deductible does not apply)  | 80% (deductible does not apply)  | 100% (deductible does not apply)  | 80% (deductible does not apply)  |
| Diagnostic services and procedures   | 100% (deductible does not apply)  | 80% after deductible             | 100% (deductible does not apply)  | 80% after deductible             |
| <b>Emergency Services</b>  |   |                                  |   |                                  |
| <b>Emergency Room Services</b>   | 100% after \$100 copayment (waived if admitted)   |                                  | 100% after \$100 copayment (waived if admitted)   |                                  |
| <b>Ambulance – Emergency</b> <sup>(5)</sup>  | 100% after deductible   |                                  | 100% after deductible   |                                  |
| <b>Ambulance – Non-Emergency</b> <sup>(5)</sup>  | 100% after deductible   | 80% after deductible             | 100% after deductible   | 80% after deductible             |
| <b>Hospital and Medical/Surgical Expenses (including maternity)</b>  |   |                                  |   |                                  |
| <b>Hospital Inpatient</b>  | 100% after deductible   | 80% after deductible             | 100% after deductible   | 80% after deductible             |
| <b>Hospital Outpatient</b>   | 100% after deductible   | 80% after deductible             | 100% after deductible   | 80% after deductible             |
| <b>Maternity</b> (non-preventive facility & professional services) including dependent daughter  | Facility: 100% after deductible<br>Professional: 100% after \$15 copayment  | 80% after deductible             | Facility: 100% after deductible<br>Professional: 100% after \$15 copayment  | 80% after deductible             |
| <b>Medical Care</b> (including inpatient visits and consultations)/ <b>Surgical Expenses</b>   | 100% after deductible   | 80% after deductible             | 100% after deductible   | 80% after deductible             |
| <b>Therapy and Rehabilitation Services</b>   |   |                                  |   |                                  |
| Copayment, if any, does not apply to Therapy visits prescribed for the treatment of Mental Health or Substance Abuse   |   |                                  |   |                                  |
| <b>Physical Medicine</b>   | 100% after \$20 copayment per provider per date of service  | 80% after deductible             | 100% after \$20 copayment per provider per date of service  | 80% after deductible             |
| <b>Respiratory Therapy</b>   | 100% after deductible   |                                  | 100% after deductible   |                                  |

| Benefit  | Performance Blue PPO   |                      | PPO Blue  |                      |
|--|--|----------------------|---|----------------------|
|  | In-Network   | Out-of-Network       | In-Network  | Out-of-Network       |
| <b>Speech &amp; Occupational Therapy</b>   | 100% after \$20 copayment per provider per date of service   | 80% after deductible | 100% after \$20 copayment per provider per date of service  | 80% after deductible |
| <b>Spinal Manipulations &amp; Acupuncture</b>  | 100% after \$20 copayment per provider per date of service   | 80% after deductible | 100% after \$20 copayment per provider per date of service  | 80% after deductible |
| <b>Other Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy & Dialysis)  | 100% after deductible  | 80% after deductible | 100% after deductible   | 80% after deductible |
| <b>Mental Health / Substance Abuse</b>   |  |                      |   |                      |
| <b>Inpatient</b>   | 100% after deductible  | 80% after deductible | 100% after deductible   | 80% after deductible |
| <b>Inpatient Detoxification/Rehabilitation</b>   | 100% after deductible  | 80% after deductible | 100% after deductible   | 80% after deductible |
| <b>Outpatient Mental Health- Includes Virtual Behavioral Health Visits</b>   | 100% after \$15 copayment  | 80% after deductible | 100% after \$15 copayment   | 80% after deductible |
| <b>Outpatient Substance Abuse Services</b>   | 100% after \$15 copayment  | 80% after deductible | 100% after \$15 copayment   | 80% after deductible |
| <b>Other Services</b>  |  |                      |   |                      |
| <b>Allergy Extracts and Injections</b>   | 100% after deductible  | 80% after deductible | 100% after deductible   | 80% after deductible |
| <b>Autism Spectrum Disorder including Applied Behavior Analysis</b> (6)  | 100% after deductible  | 80% after deductible | 100% after deductible   | 80% after deductible |
|  | \$40,000 maximum per member per plan year (includes prescription drug)   |                      | \$40,000 maximum per member per plan year (includes prescription drug)  |                      |
| <b>Assisted Fertilization Procedures</b>   | Not Covered  |                      | Not Covered   |                      |
| <b>Dental Services Related to Accidental Injury</b>  | 100% after deductible  | 80% after deductible | 100% after deductible   | 80% after deductible |
| <b>Diagnostic Services</b>   | Copayment, if any, does not apply to Diagnostic services prescribed for the treatment of Mental Health or Substance Abuse  |                      |   |                      |
| <i>Advanced Imaging</i><br>(MRI, CAT, PET scan, etc.)  | (7) <b>Member Savings Site:</b><br>100% after deductible<br><b>All Other Network Providers:</b><br>\$50 copayment then<br>100% after deductible  | 80% after deductible | (6) <b>Member Savings Site:</b><br>100% after deductible<br><b>All Other Network Providers:</b><br>\$50 copayment then<br>100% after deductible   | 80% after deductible |
| <i>Basic Diagnostic Services</i><br>(standard imaging and lab/pathology)   | (7) <b>Member Savings Site:</b><br>100% after deductible<br><b>All Other Network Providers:</b><br>\$50 copayment then<br>100% after deductible  | 80% after deductible | (6) <b>Member Savings Site:</b><br>100% after deductible<br><b>All Other Network Providers:</b><br>\$50 copayment then<br>100% after deductible   | 80% after deductible |
| <i>Basic Diagnostic Services</i><br>(diagnostic medical and allergy testing)   | (7) <b>Freestanding Facility :</b><br>100% after deductible<br><b>All Other Network Providers :</b><br>\$50 copayment then<br>100% after deductible  | 80% after deductible | (6) <b>Freestanding Facility:</b><br>100% after deductible<br><b>All Other Network Providers:</b><br>\$50 copayment then<br>100% after deductible | 80% after deductible |
| <b>Durable Medical Equipment, Orthotics &amp; Prosthetics</b>  | 100% after deductible  | 80% after deductible | 100% after deductible   | 80% after deductible |
| <b>Routine Eye Exam / Foot Care Services</b>   | 100% after deductible  | 80% after deductible | 100% after deductible   | 80% after deductible |
| <b>Hearing Aids</b>  | 100% after deductible  | 80% after deductible | 100% after deductible   | 80% after deductible |
|  | Limit: Up to \$300 per ear 48 months after previous purchase   |                      | Limit: Up to \$300 per ear 48 months after previous purchase  |                      |
| <b>Home Health Care</b> (8)  | 100% after deductible  | 80% after deductible | 100% after deductible   | 80% after deductible |
|  | Limit: 120 visits/plan year  |                      | Limit: 120 visits/plan year   |                      |
| <b>Hospice</b>   | 100% after deductible  | 80% after deductible | 100% after deductible   | 80% after deductible |
| <b>Infertility Counseling, Testing &amp; Treatment</b> (9)   | 100% after deductible  | 80% after deductible | 100% after deductible   | 80% after deductible |
| <b>Private Duty Nursing</b>  | 100% after network deductible  |                      | 100% after network deductible   |                      |
| <b>Skilled Nursing Facility Care</b>   | 100% after deductible  | 80% after deductible | 100% after deductible   | 80% after deductible |
| <b>Transplant Services</b>   | 100% after deductible  | 80% after deductible | 100% after deductible   | 80% after deductible |
| <b>Precertification Requirements</b> (10)  | YES  |                      | YES   |                      |
| <b>Prescription Drug Program</b><br>Hard Mandatory Generic (11)<br>Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. (12)<br><br>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design (13,14) | <b>Retail Drugs (up to 31 day Supply)</b><br>\$10 copay (generic)<br>\$25 copay (formulary brand)<br>\$50 copay (non-formulary brand)<br><b>Maintenance Prescription Drug Third fill at Retail Pharmacy</b><br><b>Maintenance Drugs through Mail Order or CVS (90-day Supply)</b><br>\$20 copay (generic)<br>\$50 copay (formulary brand)<br>\$100 copay (non-formulary brand) |                      |   |                      |

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 benefit summary.

- Your group's plan year is based on a Calendar Year, January 1 through December 31.
- 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.
- 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 / Substance Abuse benefit.
- Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
- Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits.
- 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.
- Member Savings Sites are independent laboratories and x-ray / imaging centers that perform diagnostic services at a reduced rate as well as Ambulatory Surgical Centers that are multispecialty and those delivering surgeries. Many providers may send their services out to a hospital for processing causing a facility charge in addition to the professional component, resulting in higher cost share for the member. When members use a Member Savings Site they can be confident that they will pay a lower cost share (i.e. not encountering multiple copays).
- The maternity home health care visit for network care is not subject to the program copayment, coinsurance or deductible amounts, if applicable. See Maternity Home Health Care Visit in the Covered Services section.
- Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Contact Highmark Customer Service for the exact benefit.
- 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 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.
- Under the hard mandatory generic provision, 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. Regardless if the patient or provider requested the brand name.
- Certain retail participating pharmacy providers may have agreed to make covered medications available at the same cost-sharing and quantity limits as the mail order coverage. You may contact Highmark at 1-866-594-1732 or the website at MyHighmark.com for a listing of those pharmacies who have agreed to do so.
- The quantity level limit for your initial prescription order may be reduced, depending on the particular medication, to a quantity level necessary to establish that you can tolerate the medication. The cost-sharing provision indicated above will be adjusted accordingly for the initial prescription order based upon the initial quantity dispensed. If you are able to tolerate the medication, the remainder of the available days supply for the initial prescription order will be filled and you will be responsible for the balance of the applicable cost-sharing amount indicated above.
- The Highmark 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 and may, from time to time, be revised by the committee. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. With the Smart90 CVS Network, after two fills at a retail pharmacy that is not CVS you must choose between a 90-day supply through CVS retail pharmacy stores or through Express Scripts Mail Order Pharmacy.

#### DISCLAIMER

The Laborers' District Council of Western Pennsylvania Welfare Fund and the Laborers' Combined Funds have prepared this summary for overview purposes only and all benefits effective are subject to the descriptions, definitions, and other details in the Welfare Fund Summary Plan Description and are tentative and subject to final review.