Immanuel CopayGo HDHP 1/1/2027

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. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out of pocket. 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
	Enhanced Value	Standard Value	
General Provisions			
Effective Date	**1/1/2027**		
Benefit Period (1)	Contract Year		
Deductible (per benefit period) (All in-network services are credited to both the enhanced and the standard deductibles.) Individual Family	 $1,750 $3,500	 $3,500 $7,000	 $5,000 $10,000
Deductible Accumulation (2)	Non-embedded	Non-embedded	Non-embedded
Plan Pays – payment based on the plan allowance	100%		70% after deductible
Out-of-Pocket Maximum (Includes any medical and prescription deductible, copays and coinsurance). Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $6,000 $10,000		 $10,000 $20,000
Out-of-Pocket Accumulation (2)	Non-embedded		Non-embedded
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	$25 copay after enhanced deductible		70% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	$25 copay after deductible	$60 copay after deductible	70% after deductible
Specialist Office Visits & Virtual Visits	$50 copay after deductible	$100 copay after deductible	70% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	100% after deductible	70% after deductible
Urgent Care Center Visits	$50 copay after enhanced deductible		70% after deductible
	copay does not apply to urgent care center visits prescribed for the treatment of mental health or substance abuse.		
On-Demand Telemedicine Services (3)	Carved out to HealthJoy		
Preventive Care (4)			
Routine Adult Physical exams	 100% (deductible does not apply)		 70% after deductible
Adult immunizations	100% (deductible does not apply)		70% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)		70% (deductible does not apply)
Breast Cancer Screenings	100% (deductible does not apply)		70% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)		70% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)		70% after deductible
Diagnostic services and procedures	100% (deductible does not apply)		70% after deductible
Routine Pediatric Physical exams	 100% (deductible does not apply)		 70% after deductible
Pediatric immunizations	100% (deductible does not apply)		70% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)		70% after deductible
Emergency Services			
Emergency Room Services (5)	$500 copay after enhanced deductible (waived if admitted)		
Ambulance - Emergency	$500 copay after enhanced deductible		
Ambulance - Non-Emergency (6)	$500 copay after enhanced deductible		70% after deductible
Hospital and Medical/Surgical Expenses (5)			
Hospital Inpatient (including maternity)	100% after $1,500 inpatient copay after enhanced deductible/admission		70% after deductible
Hospital Outpatient (11)	see service category (i.e. lab, surgery, imaging)		70% after deductible

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Outpatient Surgery (facility)	$750 copay after enhanced deductible		70% after deductible
Surgical Services (professional)	$25 copay after deductible for PCP; $50 copay after deductible for Specialist	$60 copay after deductible for PCP; $100 copay after deductible for Specialist	70% after deductible
Maternity (non-preventive professional services) including dependent daughter	$40 copay after deductible for PCP; $40 copay after deductible for Specialist (one copay on global professional bill)	$70 copay after deductible for PCP; $60 copay after deductible for Specialist (one copay on global professional bill)	70% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	100% after deductible	70% after deductible
Therapy Services			
Physical Medicine	$40 copay after enhanced deductible		70% after deductible
	limit: 60 visits/benefit period combined with speech and occupational therapy - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse.		
Speech Therapy	$40 copay after enhanced deductible		70% after deductible
	limit: 60 visits/benefit period combined with physical medicine and occupational therapy. Limit does not apply when rehabilitative or habilitative speech therapy services are prescribed for the treatment of childhood stuttering. Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse.		
Occupational Therapy	$40 copay after enhanced deductible		70% after deductible
	limit: 60 visits/benefit period combined with physical medicine and speech therapy - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse.		
Respiratory Therapy	$40 copay after deductible	$80 copay after deductible	70% after deductible
Spinal Manipulations	$40 copay after enhanced deductible		70% after deductible
	limit: 20 visits/benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	$40 copay after deductible	$120 copay after deductible	70% after deductible
Mental Health/Substance Abuse			
Inpatient Mental Health Services	$1,500 inpatient copay after enhanced deductible/admission		70% after deductible
Inpatient Detoxification/Rehabilitation	$1,500 inpatient copay after enhanced deductible/admission		70% after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	$30 copay after deductible	$90 copay after deductible	70% after deductible
Outpatient Substance Abuse	$30 copay after deductible	$90 copay after deductible	70% after deductible
Other Services			
Allergy Extracts	100% after deductible	100% after deductible	70% after deductible
Allergy Injections	$40 copay after deductible	$120 copay after deductible	70% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)	70% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered	Not Covered
Dental Services Related to Accidental Injury (11)	Not Covered	Not Covered	Not Covered
Diabetes Treatment Equipment and Supplies	$40 copay after deductible	$120 copay after deductible	70% after deductible
Diabetes Education Program	100% after deductible	100% after deductible	70% after deductible
Diagnostic Services	Copay does not apply to diagnostic services prescribed for the treatment of mental health or substance abuse		
Advanced Imaging (MRI, CAT, PET scan, etc.)	$200 copay after deductible	$600 copay after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	$40 copay after deductible	$120 copay after deductible	70% after deductible
Mammograms (medically necessary)	100% after enhanced deductible		70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	$40 copay after deductible	$120 copay after deductible	70% after deductible
Enteral Foods	100% after deductible	100% after deductible	70% after deductible
Home Health Care	$40 copay after enhanced deductible		70% after deductible
	limit: 90 visits/benefit period aggregate with visiting nurse		
Home Infusion and Suite Infusion Therapy	$40 copay after deductible	$120 copay after deductible	70% after deductible
Hospice	$40 copay after enhanced deductible		70% after deductible
Infertility Counseling, Testing and Treatment (8) (11)	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)	70% after deductible
Private Duty Nursing	$40 copay after enhanced deductible		70% after deductible

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
	limit: 240 hours/benefit period		
Skilled Nursing Facility Care	$1,500 inpatient copay after enhanced deductible/admission		70% after deductible
	limit: 100 days / benefit period		
Therapeutic Injections	$40 copay after deductible	$120 copay after deductible	70% after deductible
Transplant Services (11)	see service category (i.e. lab, surgery, imaging)	see service category (i.e. lab, surgery, imaging)	70% after deductible
Precertification/Authorization Requirements (9)	Yes		
Prescription Drugs			
Prescription Drug Individual Family	Integrated with Medical Integrated with Medical		
Prescription Drug Program (10) SensibleRx Complete Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the National Select Formulary with an Incentive Benefit Design. **Select Specialty Drugs are Limited to a 31-Day Supply**	**Retail Drugs (31/60/90-day supply)** Generic: $10/$20/$40 copay after enhanced deductible Formulary brand: $35/$70/$105 copay after enhanced deductible Non-formulary brand: $65/$130/$195 copay after enhanced deductible **Maintenance Drugs through Mail Order (90-day Supply)** Generic: $20 copay after enhanced deductible Formulary brand: $70 copay after enhanced deductible Non-formulary brand: $130 copay after enhanced deductible		

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) 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 OOP, once any eligible family member satisfies his/her individual OOP, claims will pay 100% of the plan allowance for covered expenses for the rest of the plan year. Claims for the remaining family members will pay 100% once the family OOP is met.
3) On-Demand 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 (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) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services-Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders 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). Services for the treatment of Autism Spectrum Disorders do 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 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 Complete, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug member cost share indicated plus the difference in cost between the brand and generic drugs. Your plan requires that you use a specific specialty pharmacy for hemophilia medications. Please contact member services for more details. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary.
11) Covered services will be covered according to the benefit category to which they apply (e.g. outpatient surgery, hospital inpatient, diagnostic services.

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