2017 EPO 80% Plan

On the chart below, you'll see what your plan pays for specific services. You are responsible for paying for non-emergency services received from an out-of-network provider. 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.

Wabtec Corporation

Group Numbers 11311-04. 14

Wabtec Corporation	Group Numbers 11311-04, 14	
Benefit	In Network	
General Pr		
Benefit Period(1)	Calendar Year	
Deductible (per benefit period) Individual	\$700	
Plan Pays – payment based on the plan allowance	80% after deductible	
Out-of-Pocket Limit (Excludes copayments, prescription drug,	80% after deductible	
deductible and amounts over UCR. Once met, plan pays 100%		
coinsurance for the rest of the benefit period)		
comparation for the root of the bottom portion,	40.000	
Each Family Member	\$2,300	
Total Maximum Out-of-Pocket (Includes deductible, coinsurance,		
copays, and other qualified medical expenses, Network only. Excludes		
prescription drug expenses.) (2) Once met, the plan pays 100% of		
covered services for the rest of the benefit period.		
Individual	\$4,600	
Family	\$9,200	
Office/Clinic/Urg		
Primary Care Provider Office Visits	100% after \$25 copay	
Retail Clinic Visits	100% after \$35 copay	
Specialist Office Visits	100% after \$35 copay	
Urgent Care Center Visits	100% after \$35 copay	
Telemedicine Services (Teladoc) (3)	100% after \$10 copay	
Preventive Preventive	Care (4)	
Routine Adult Physical Evamo	100% (deductible does not apply)	
Physical Exams	100% (deductible does not apply)	
Adult Immunizations	100% (deductible does not apply)	
Colorectal cancer screening (includes colonoscopy; sigmoidoscopy;	4000/ (deducatible deservational)	
barium enema; blood occult)	100% (deductible does not apply)	
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	
Mammograms, Annual Routine	100% (deductible does not apply)	
	100% no deductible for the first mammogram of the year and all	
Mammograms, Medically Necessary	related services subsequent mammograms and related services	
	follow program deductible	
Routine Pediatric	4000/ /	
Physical Exams	100% (deductible does not apply)	
Pediatric Immunizations	100% (deductible does not apply)	
Emergency Services		
Emergency Room Services(5)	80% after \$200 copay (deductible does not apply)	
	(waived if admitted)	
Ambulance - Emergency and Non-Emergency	80% after deductible	
Hospital and Medical / Surgical	Expenses (including maternity)	
Hospital Inpatient	80% after deductible	
Hospital Outpatient	80% after deductible	
Maternity (non-preventive facility & professional services) including		
dependent daughter	80% after deductible	
Medical Care (including inpatient visits and consultations)/Surgical	000/ effect de disabilit	
Expenses	80% after deductible	
Therapy and Rehabilitation Services		
Physical Medicine	80% after deductible	
Respiratory Therapy	80% after deductible	
	80% after deductible	
Speech Therapy		
Occupational Therapy	80% after deductible	

limit: 20 visits/benefit period ther Therapy Services (Cardiac Rehab, Infusion Therapy, hemotherapy, Radiation Therapy and Dialysis) Mental Health / Substance Abuse patient spatient Detoxification / Rehabilitation upatient Detoxification / Rehabilitation Utipatient 100% after \$35 copay (deductible does not apply) Other Services Illergy Extracts and Injections 80% after deductible utism Spectrum Disorder Including Applied Behavior Analysis (6) 80% after deductible sisted Fertilization Procedures not covered ental Services Related to Accidental Injury 80% after deductible ilagnostic Services dvanced Imaging (MRI, CAT, PET scan, etc.) Hospital Based Imaging Center (non-emergent / non-inpatient) Non-Hospital Based Imaging Center (non-emergent / non-inpatient) asic Diagnostic Services (standard imaging, diagnostic medical, lergy testing) ab/Pathology Hospital Based Lab (non-emergent / non-inpatient) Non-Hospital Based Lab (non-emergent / non-inpat	Benefit	In Network	
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ransplant Services 80% after deductible	Transplant Services	80% after deductible	
recertification Requirements (8) Yes	Precertification Requirements (8)	Yes	

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) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, and any qualified medical expense.
- (3) 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 benefit.
- (4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
- (5) Emergency Room Services that are Out of Network will process at the In-Network Level
- (6) 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.
- (7) Treatment includes coverage for the correction of a physical or medical problem associated with infertility.
- (8) 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.