2019 HDHP EPO Plan

This program is a qualified high deductible plan as defined by the Internal Revenue Service. 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. . **If you enroll as an individual, the deductible and out-of-pocket maximums for the "Employee Only Plan" apply. If you enroll as a family, the deductible and out-of -pocket maximums for the "Family Plan" apply and can be satisfied by one or more of your family members.**

Wabtec Corporation **Group Number 11311-08, -48**

Benefit	In Network
General Provisions	
Benefit Period(1)	Contract Year
Deductible (per benefit period) Employee Only Plan Family Plan	 $1,500 $3,400
Plan Pays – payment based on the plan allowance	80% after deductible
Out-of-Pocket Limit (Includes prescription drug expenses, coinsurance and copays. Once met, plan pays 100% coinsurance for the rest of the benefit period) Employee Only Plan Family Plan	 $3,000 $6,550
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. Employee Only Plan Family Plan	 $3,000 $6,550
Office/Clinic/Urgent Care Visits	
Primary Care Provider Office Visits	80% after deductible
Retail Clinic Visits	80% after deductible
Specialist Office Visits	80% after deductible
Urgent Care Center Visits	80% after deductible
Telemedicine Services (Teladoc) (3)	100% after deductible
Preventive Care (4)	
Routine Adult Physical Exams	 100% (deductible does not apply)
Adult Immunizations	100% (deductible does not apply)
Colorectal cancer screening (includes colonoscopy; sigmoidoscopy; 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)
Mammograms, Medically Necessary	80% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)
Pediatric Immunizations	100% (deductible does not apply)
Emergency Services	
Emergency Room Services (5)	80% after deductible
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 Expenses	80% after deductible
Therapy and Rehabilitation Services	
Physical Medicine, Respiratory Therapy, Speech Therapy, and Occupational Therapy	80% after deductible
Spinal Manipulations	80% after deductible limit: 20 visits/benefit period
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible
Mental Health / Substance Abuse	
Inpatient Mental Health Inpatient Detoxification / Rehabilitation Services	80% after deductible
Outpatient Mental Health Services	80% after deductible

Benefit	In Network
Other Services	
Allergy Extracts and Injections	80% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (6)	80% after deductible
Assisted Fertilization Procedures	not covered
Dental Services Related to Accidental Injury	80% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan)	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible
Home Health Care	80% after deductible
Hospice	80% after deductible
Infertility Counseling, Testing and Treatment (7)	80% after deductible
Private Duty Nursing	80% after deductible
Skilled Nursing Facility Care	80% after deductible
Transplant Services	80% after deductible
Precertification Requirements (8)	Yes
Prescription Drugs	
Prescription Drug Individual Family	 Integrated with medical Integrated with medical
National Plus Prescription Drug Program(9) *(Defined by National Plus Pharmacy Network - Not Physician Network)* Hard Mandatory Generic Program Quantity Level Limit Program Walgreens Specialty Pharmacy Program Step Therapy Program	**Retail Drugs** 31 day supply 80% after deductible **Mandatory Maintenance** **Mail Order** 90 day supply 80% after deductible ** **Maintenance**: member allowed 2 fills at pharmacy then it will be mandatory mail order **
Preventive Medication List *Defined by National Plus Pharmacy Network - Not Physician Network.* *Prescriptions filled at a non-network pharmacy are not covered.*	**Value Preventive Medication List** **Retail Drugs (31 day supply)** Plan pays 80% (deductible does not apply) **Maintenance Drugs through Mail Order (90-day Supply)** Plan pays 80% (deductible does not apply)

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, and any qualified medical expense. If you are enrolled as an individual, the deductible, out-of-pocket limit and TMOOP for the "Employee Only" plan apply. 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 non-embedded TMOOP, once the entire family TMOOP is satisfied, claims will pay at 100% of the plan allowance for covered expenses for the family, for the rest of the plan year.
(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.
(9) 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. This formulary covers all FDA-approved generic and brand-name drugs.

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.