2017 EPO 80% Plan

Effective November 1, 2017

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

Benefit	In Network
General Provisions	
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, deductible and amounts over UCR. Once met, plan pays 100% coinsurance for the rest of the benefit period) 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 Family	 $4,600 $9,200
Office/Clinic/Urgent Care Visits	
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 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	100% no deductible for the first mammogram of the year and all related services subsequent mammograms and related services follow program 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 $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 Expenses	80% after deductible
Therapy and Rehabilitation Services	
Physical Medicine	80% after deductible
Respiratory Therapy	80% after deductible
Speech Therapy	80% after deductible
Occupational Therapy	80% after deductible

Benefit	In Network
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 Inpatient Detoxification / Rehabilitation	80% after deductible
Outpatient	100% after $35 copay (deductible does not apply)
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, etc.) Hospital Based Imaging Center *(non-emergent / non-inpatient)*	80% after deductible plus $100 copay
Non-Hospital Based Imaging Center *(non-emergent / non-inpatient)*	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, allergy testing)	80% after deductible
Lab/Pathology Hospital Based Lab *(non-emergent / non-inpatient)*	80% after deductible plus $40 copayment
Non-Hospital Based Lab *(non-emergent / non-inpatient)*	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible
Home Health Care / Visiting Nurse	80% after deductible
Hospice	80% after deductible
Infertility Counseling, Testing and Treatment (7)	80% after deductible
Private Duty Nursing (Outpatient Only)	80% after deductible
Skilled Nursing Facility Care	80% after deductible
Transplant Services	80% after deductible
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.