# Advanced Industrial Services, Inc

# Choice Blue PPO

**Groups #10527402 (Active) & 10527403 (COBRA)**

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** | | | |
| **Benefit Period (1)** | Contract Year (10/1 – 9/30) | | |
| **Deductible** (per benefit period) (All in-network services are credited to both the enhanced and the standard deductibles.)<br>Individual<br>Family | <br>$1,000<br>$2,000 | <br>$1,250<br>$2,500 | <br>$3,500<br>$7,000 |
| **Plan Pays –** payment based on the plan allowance | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| **Out-of-Pocket Limit** (Once met, plan pays 100% coinsurance for the rest of the benefit period) (All in-network services are credited to both the enhanced and the standard out-of-pocket limits.)<br>Individual<br>Family | <br>$1,000<br>$2,000 | <br>$1,250<br>$2,500 | <br>$12,500<br>$25,000 |
| **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.<br>Individual<br>Family | <br>$7,900<br>$15,800 | | <br>Not Applicable<br>Not Applicable |
| **Office/Clinic/Urgent Care Visits** | | | |
| **Retail Clinic Visits & Virtual Visits** | 100% After $20 Copayment | 100% After $40 Copayment | 40% After Deductible |
| **Primary Care Provider Office Visits & Virtual Visits** | 100% After $20 Copayment | 100% After $40 Copayment | 40% After Deductible |
| **Specialist Office & Virtual Visits** | 100% After $40 Copayment | 100% After $80 Copayment | 40% After Deductible |
| Virtual Visit Provider Originating Site Fee | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| **Urgent Care Center Visits** | 100% After $30 Copayment | 100% After $60 Copayment | 40% After Deductible |
| **Telemedicine Services (3)** | 100% After $15 Copayment | | Not Covered |
| **Preventive Care (4)** | | | |
| **Routine Adult**<br>Physical exams | 100% (Deductible Does Not Apply) | | 40% After Deductible |
| Adult immunizations | 100% (Deductible Does Not Apply) | | 40% After Deductible |
| Routine gynecological exams, including a Pap Test | 100% (Deductible Does Not Apply) | | 40% (Deductible Does Not Apply) |
| Mammograms, annual routine and medically necessary | 100% (deductible does not apply for the first mammogram and all related services, per benefit period) (subsequent mammograms subject to program deductible | | 40% After Deductible |
| Colorectal Cancer Screening or Procedure – For the first screening of plan year and all related services | 100% (deductible does not apply) | | 40% After Deductible |
| Prostate Cancer Screening (PSA)<br>Procedure codes: G0102, G0103, 84152, 84153, 84154 | 100% (deductible does not apply) | | |
| Diagnostic services and procedures | 100% (Deductible Does Not Apply) | | 40% After Deductible |
| **Routine Pediatric**<br>Physical exams | 100% (Deductible Does Not Apply) | | 40% After Deductible |

| Benefit | Network | | Out-of-Network |
|---|---|---|---|
| | Enhanced Value | Standard Value | |
| Pediatric immunizations | 100% (Deductible Does Not Apply) | | 40% (Deductible Does Not Apply) |
| Diagnostic services and procedures | 100% (Deductible Does Not Apply) | | 40% After Deductible |
| **Hospital and Medical/Surgical Expenses (including maternity)** | | | |
| **Hospital Inpatient** | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| **Hospital Outpatient (Non-Surgical)** | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| **Outpatient Surgery** | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| **Maternity** (non-preventive facility & professional services) including dependent daughter | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| **Medical Care** (including inpatient visits and consultations) | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| **Emergency Services** | | | |
| **Emergency Room Services** | 100% After $200 Copayment (Waived If Admitted) | | |
| **Ambulance - Emergency** | 100% After Enhanced Deductible | | |
| **Ambulance – Non-Emergency** | 90% After Enhanced Deductible | | 40% After Deductible |
| **Therapy and Rehabilitation Services** | | | |
| **Physical Medicine** | 100% After $40 Copayment | 100% After $80 Copayment | 40% After Deductible |
| | **Benefit Limit:** 30 Visits/Benefit Period | | |
| **Respiratory Therapy** | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| **Speech Therapy** | 100% After $40 Copayment | 100% After $80 Copayment | 40% After Deductible |
| | **Benefit Limit:** 30 Visits/Benefit Period | | |
| **Occupational Therapy** | 100% After $40 Copayment | 100% After $80 Copayment | 40% After Deductible |
| | **Benefit Limit:** 30 Visits/Benefit Period | | |
| **Spinal Manipulations** | 100% After $40 Copayment | 100% After $80 Copayment | 40% After Deductible |
| | **Benefit Limit:** 30 Visits/Benefit Period | | |
| **Other Therapy Services** (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| **Mental Health/Substance Abuse** | | | |
| **Inpatient Mental Health Services** | 90% After Enhanced Deductible | | 40% After Deductible |
| **Inpatient Detoxification/Rehabilitation** | 90% After Enhanced Deductible | | 40% After Deductible |
| **Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits** | 100% After $40 Copayment | | 40% After Deductible |
| **Outpatient Substance Abuse** | 90% After Enhanced Deductible | | 40% After Deductible |
| **Other Services** | | | |
| **Allergy Extracts and Injections** | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| **Applied Behavior Analysis for Autism Spectrum Disorder (5)** | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| | $36, 000/benefit period | | |
| **Assisted Fertilization Procedures** | Not Covered | | Not Covered |
| **Dental Services Related to Accidental Injury** | 90% After Enhanced Deductible | 80% After Standard Deductible | 40% After Deductible |
| **Diagnostic Services**<br>*Advanced Imaging* (MRI, CAT, PET scan, etc.) | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| *Basic Diagnostic Services* (standard imaging, diagnostic medical, lab/pathology, allergy testing) | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| **Durable Medical Equipment, Orthotics and Prosthetics** | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| **Home Health Care** | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| | **Benefit Limit:** 90 Visits/Benefit Period | | |
| **Hospice** | 90% After Enhanced Deductible | | 40% After Deductible |
| **Infertility Counseling, Testing and Treatment (6)** | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| **Private Duty Nursing** | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| | **Benefit Limit:** 240 Hours/Benefit Period | | |
| **Skilled Nursing Facility Care** | 90% After Deductible | 80% After Deductible | 40% After Deductible |
| | **Benefit Limit:** 100 Days/Benefit Period | | |
| **Transplant Services** | 90% After Enhanced Deductible | | 40% After Deductible |
| **Precertification/Authorization Requirements(7)** | Yes | | |
| | | | |
| **Prescription Drugs** | | | |
| **Prescription Drug Deductible**<br>Individual<br>Family | None<br>None | | |

| Benefit | Network | | Out-of-Network |
|---|---|---|---|
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| **Prescription Drug Program**(8)<br>Hard Mandatory Generic<br>*Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.*<br><br>*Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.*<br><br>Excludes High Cost Low Value Drugs: Yes<br>Excludes New to Market Drugs: Yes<br>Excludes Rx Drugs with OTC Equivalents: Yes | **Retail Drugs (31 Day Supply)**<br>$10 Formulary Generic Copay<br>$10 Non-Formulary Generic Copay<br>$35 Formulary Brand Copay<br>$65 Non-Formulary Brand Copay<br><br>**Specialty Drugs are limited to 31 day supply**<br>$200 Formulary Specialty Copay<br>$200 Non-Formulary Specialty Copay<br><br>**Maintenance Drugs – Mandatory Mail Order Exclusive Home Delivery (90 day supply)**<br>$20 Formulary Generic Copay<br>$20 Non-Formulary Generic Copay<br>$70 Formulary Brand Copay<br>$130 Non-Formulary Brand Copay | | |

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.

**The terms "Enhanced Value" and "Standard Value" are not descriptors of the provider's ability.*

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, prescription drug cost share 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 Enhanced Highmark Preventive Schedule with addition of Procedures Codes: 80053, 80050, 84443, 82306, 85025, 85027, 80048, 82270, 82272 (one per calendar year), 99000 as needed and Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply
5) Coverage for eligible members to age 21. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
6) 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.
7) Be sure your provider is aware that Highmark Utilization Management must be contacted for authorization prior to a planned inpatient admission or within 48 hours of an emergency or unplanned inpatient admission. Also note that certain outpatient procedures require prior authorization. If authorization 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.
8) 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. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. 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. . With the Exclusive Home Delivery program, you can have your maintenance prescription drugs filled two times at a retail pharmacy location. After that, you must have your maintenance prescription drugs filled through the mail order program. 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. With the Exclusive Home Delivery program, you can have your maintenance prescription drugs filled at a retail pharmacy location two times. After that, you must have your maintenance prescription drugs filled through the mail order program.

**Discrimination is Against the Law**

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the claims administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

*Please note that your plan sponsor – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/program.*

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ប្រការចង់ចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក ( TTY: 711 )។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود ( TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दनिुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। तपाईंको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).