Riser Holdings, L.P. dba NSM Insurance – H S A $2,800Q $35/$50

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. 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
General Provisions		
Effective Date	01/01/2025	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 $2,800 $5,600	 $8,400 $16,800
Plan Pays – payment based on the plan allowance	100% after deductible	50% after deductible
Out-of-Pocket Limit (Includes prescription drug expenses, coinsurance, and copayments). Once met, the plan pays 100% coinsurance for the rest of the benefit period. Individual Family	 None None	 $10,000 $20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copayments, 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. Individual Family	 $3,500 $7,000	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	$35 copayment after deductible	50% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	$35 copayment after deductible	50% after deductible
Specialist Office Visits & Virtual Visits	$50 copayment after deductible	50% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	50% after deductible
Urgent Care Center Visits	$50 copayment after deductible - copayment does not apply to Urgent Care Center Visits prescribed for the treatment of Mental Health or Substance Abuse	50% after deductible
Telemedicine Services (3)	100% after deductible	Not Covered
Preventive Care (4)		
Routine Adult Physical exams	 100% (deductible does not apply)	 50% after deductible
Adult immunizations	100% (deductible does not apply)	50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	50% (deductible does not apply)
Breast Cancer Screenings (annual routine and supplemental)	100% (deductible does not apply)	50% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	50% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric Physical exams	 100% (deductible does not apply)	 50% after deductible
Pediatric immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Hospital and Medical/Surgical Expenses (including maternity) (5)		
Hospital Inpatient	100% after deductible	50% after deductible
Outpatient Surgery	100% after deductible	50% after deductible
Maternity (non-preventive professional services) including dependent daughter	100% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	50% after deductible
Emergency Services		
Emergency Room Services (5)	100% after network deductible	
Ambulance – Emergency	100% after network deductible	
Ambulance – Non-Emergency (6)	100% after network deductible	50% after deductible

Therapy and Rehabilitation/Habilitation Services		
Physical Medicine / Occupational Therapy	$50 copayment after deductible	50% after deductible
	Benefit Limit: 30 visits combined/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Speech Therapy	$50 copayment after deductible	50% after deductible
	Benefit Limit: 20 visits/benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Respiratory Therapy	100% after deductible	50% after deductible
Spinal Manipulations	$50 copayment after deductible	50% after deductible
	Benefit Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	50% after deductible
Mental Health/Substance Abuse		
Inpatient Mental Health Services	100% after deductible	50% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	50% after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	$50 copayment after deductible	50% after deductible
Outpatient Substance Abuse	$50 copayment after deductible	50% after deductible
Other Services		
Acupuncture	$50 copayment after deductible	50% after deductible
	Benefit Limit: 18 visits/benefit period	
Allergy Extracts and Injections	100% after deductible	50% after deductible
Autism Spectrum Disorder Applied Behavioral Analysis (7)	100% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	100% after deductible	50% after deductible
Diagnostic Services	Copayments, if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse	
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	50% after deductible
Mammograms (medically necessary)	100% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	50% after deductible
Home Health Care	100% after deductible	50% after deductible
	Benefit Limit: 60 visits/benefit period	
Hospice	100% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (8)	100% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	50% after deductible
	Benefit Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after deductible	50% after deductible
	Benefit Limit: 120 days/benefit period	
Transplant Services	100% after deductible	50% after deductible
Precertification/Authorization Requirements (9)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual Family	 Integrated with medical deductible Integrated with medical deductible	
Prescription Drug Program (10) SensibleRx Choice Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with Incentive Benefit Design. **Select Specialty Drugs are Limited to a 31-Day Supply**	**Retail Drugs (31/60/90-day Supply)** Generic: $20 / $40 / $60 copayment after network deductible Formulary Brand: $40 / $ 80 / $120 copayment after network deductible Non-Formulary Brand: $70 / $140 / $210 copayment after network deductible **Specialty Drugs (31-day Supply)** Member pays 50% for specialty drugs with $500 maximum per prescription after network deductible **Maintenance Drugs through Mail Order (90-day Supply)** Generic: $40 copayment after network deductible Formulary Brand: $80 copayment after network deductible Formulary Non-Brand: $140 copayment after network deductible	

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.

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. 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 embedded TMOOP, once any eligible family member satisfies his/her individual TMOOP, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year. Claims for the remaining family members will pay at 100% once the family TMOOP amount is met.
3) 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 pay 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 Choice, 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, unless your doctor requests that the brand drug be dispensed. 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.