# Riser Holdings, L.P. dba NSM Insurance – PPO $250 80/50

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)<br>Individual<br>Family | <br>$250<br>$500 | <br>$750<br>$1,500 |
| **Plan Pays –** payment based on the plan allowance | 80% after deductible | 50% after deductible |
| **Out-of-Pocket Limit** (Once met, plan pays 100% coinsurance for the rest of the benefit period)<br>Individual<br>Family | <br>None<br>None | <br>$7,500<br>$15,000 |
| **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.<br>Individual<br>Family | <br>$2,500<br>$5,000 | <br>Not Applicable<br>Not Applicable |
| **Office/Clinic/Urgent Care Visits** | | |
| **Retail Clinic Visits & Virtual Visits** | 100% after $25 copayment | 50% after deductible |
| **Primary Care Provider (PCP) Office Visits & Virtual Visits** | 100% after $25 copayment | 50% after deductible |
| **Specialist Office Visits & Virtual Visits** | 100% after $50 copayment | 50% after deductible |
| Virtual Visit Provider Originating Site Fee | 80% after deductible | 50% after deductible |
| **Urgent Care Center Visits** | 100% after $75 copayment - 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% (deductible does not apply) | Not Covered |
| **Preventive Care** (4) | | |
| **Routine Adult**<br>Physical exams | <br>100% (deductible does not apply) | <br>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**<br>Physical exams | <br>100% (deductible does not apply) | <br>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 |
| **Emergency Services** | | |
| **Emergency Room Services** (5) | 100% after $300 copayment (waived if admitted) | |
| **Ambulance – Emergency** | 80% after network deductible | |
| **Ambulance – Non-Emergency** (6) | 80% after network deductible | 50% after deductible |
| **Hospital and Medical/Surgical Expenses (including maternity)** (5) | | |
| **Hospital Inpatient** | 80% after deductible | 50% after deductible |
| **Outpatient Surgery** | 80% after deductible | 50% after deductible |
| **Maternity** (non-preventive professional services) including dependent daughter | 80% after deductible | 50% after deductible |
| **Medical Care** (including inpatient visits and consultations) | 80% after deductible | 50% after deductible |

| | | |
|---|---|---|
| **Therapy and Rehabilitation/Habilitation Services** | | |
| **Physical Medicine / Occupational Therapy** | 100% after $50 copayment | 50% after deductible |
| | **Benefit Limit:** 30 visits combined/benefit period<br>- Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse | |
| **Speech Therapy** | 100% after $50 copayment | 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** | 80% after deductible | 50% after deductible |
| **Spinal Manipulations** | 100% after $50 copayment | 50% after deductible |
| | **Benefit Limit:** 20 visits/benefit period | |
| **Other Therapy Services** (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) | 80% after deductible | 50% after deductible |
| **Mental Health/Substance Abuse** | | |
| **Inpatient Mental Health Services** | 80% after deductible | 50% after deductible |
| **Inpatient Detoxification/Rehabilitation** | 80% after deductible | 50% after deductible |
| **Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits** | 100% after $50 copayment | 50% after deductible |
| **Outpatient Substance Abuse** | 100% after $50 copayment | 50% after deductible |
| **Other Services** | | |
| **Acupuncture** | 100% after $50 copayment | 50% after deductible |
| | **Benefit Limit:** 18 visits/benefit period | |
| **Allergy Extracts and Injections** | 80% after deductible | 50% after deductible |
| **Autism Spectrum Disorder Applied Behavior Analysis** (7) | 80% after deductible | 50% after deductible |
| **Assisted Fertilization Procedures** | Not Covered | Not Covered |
| **Dental Services Related to Accidental Injury** | 80% 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.) | 80% after deductible | 50% after deductible |
| Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing) | 80% after deductible | 50% after deductible |
| Mammograms (medically necessary) | 100% (deductible does not apply) | 50% after deductible |
| **Durable Medical Equipment, Orthotics and Prosthetics** | 80% after deductible | 50% after deductible |
| **Home Health Care** | 80% after deductible | 50% after deductible |
| | **Benefit Limit:** 60 visits/benefit period, aggregate with Visiting Nurse | |
| **Hospice** | 80% after deductible | 50% after deductible |
| **Infertility Counseling, Testing and Treatment** (8) | 80% after deductible | 50% after deductible |
| **Private Duty Nursing** | 80% after deductible | 50% after deductible |
| | **Benefit Limit:** 240 hours/benefit period | |
| **Skilled Nursing Facility Care** | 80% after deductible | 50% after deductible |
| | **Benefit Limit:** 120 days/benefit period | |
| **Transplant Services** | 80% after deductible | 50% after deductible |
| **Precertification/Authorization Requirements** (9) | Yes | |
| **Prescription Drugs** | | |
| **Prescription Drug Deductible**<br>Individual<br>Family | <br>None<br>None | |
| **Prescription Drug Program** (10)<br>SensibleRx Choice<br>Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.<br><br>Your plan uses the Comprehensive Formulary with Incentive Benefit Design.<br><br>**Select Specialty Drugs are Limited to a 31-day Supply** | **Retail Drugs (31/60/90-day Supply)**<br>Generic: $10 / $20 / $30 copayment<br>Formulary Brand: $40 / $80 / $120 copayment<br>Non-Formulary Brand: $70 / $140 / $210 copayment<br><br>**Specialty Drugs (31-day Supply)**<br>Member pays 50% for specialty drugs with $500 maximum per prescription<br><br>**Maintenance Drugs through Mail Order (90-day Supply)**<br>Generic: $20 copayment<br>Formulary Brand: $80 copayment<br>Non-Formulary Brand: $140 copayment | |

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, copayments, prescription drug cost share and any qualified medical expense.
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) 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 copayment 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.