



River Valley Child Development Services - SBP10 PPO 100%/70% Con Yr w/Copay RX2

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	In Network	Out of Network
General Provisions		
Effective Date	09/01/2025	
Benefit Period (1)	Contract Year	
Deductible (per benefit period)		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period.)		
Individual	None	\$12,500
Family	None	\$25,000
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	\$6,250	Not Applicable
Family	\$12,500	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$25 copayment	70% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after \$25 copayment	70% after deductible
Specialist Office Visits & Virtual Visits	100% after \$50 copayment	70% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	70% 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 Use Disorder	70% after deductible
Telemedicine Services (3)	100% after \$20 copayment	Not Covered
Preventive Care (4)		
Routine Adult		
Physical exams	100% (deductible does not apply)	70% after deductible
Adult immunizations	100% (deductible does not apply)	70% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, annual routine	100% (deductible does not apply)	70% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	70% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	70% after deductible
Pediatric immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	70% after deductible
Emergency Services		
Emergency Room Services (5)	100% after network deductible	
Ambulance – Emergency (ground, water, air)	100% after deductible	
Ambulance – Non-Emergency (ground, water) (6)	100% after deductible	70% after deductible
Ambulance – Non-Emergency (air)	100% after deductible	
Hospital and Medical/Surgical Expenses (including maternity) (5)		
Hospital Inpatient	100% after deductible	70% after deductible
Outpatient Surgery	100% after deductible	70% after deductible
Maternity (non-preventive professional services) including dependent(s)	100% after deductible	70% after deductible

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Benefit	In Network	Out of Network
Medical Care (including inpatient visits and consultations)	100% after deductible	70% after deductible
Therapy and Rehabilitation Services		
Physical Therapy	100% after \$25 copayment	70% after deductible
	Benefit Limit: 30 visits per benefit period for other than chronic pain; 20 visits per event for chronic pain (7). Includes Rehabilitative and Habilitative Services - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	
Speech Therapy	100% after \$25 copayment	70% after deductible
	Benefit Limit: Includes Rehabilitative and Habilitative Services when necessary due to a medical condition	
Occupational Therapy	100% after \$25 copayment	70% after deductible
	Benefit Limit: 30 visits per benefit period for other than chronic pain; 20 visits per event for chronic pain (7). Includes Rehabilitative and Habilitative Services - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Use Disorder	
Respiratory Therapy	100% after deductible	70% after deductible
Spinal Manipulations	100% after \$25 copayment	70% after deductible
	Benefit Limit: 30 visits per benefit period for other than chronic pain; 20 visits per event for chronic pain (7). Includes Rehabilitative and Habilitative Services	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible
Mental Health/Substance Use Disorder Services		
Inpatient Mental Health Services	100% after deductible	70% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	70% after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	100% after \$25 copayment	70% after deductible
Outpatient Substance Use Disorder Services	100% after \$25 copayment	70% after deductible
Other Services		
Acupuncture	100% after deductible	70% after deductible
	Benefit Limit: 10visits per benefit period	
Allergy Extracts and Injections	100% after deductible	70% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (8)	100% after deductible	70% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to Accidental Injury	100% after deductible	70% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.) Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing) Mammograms, medically necessary	100% after deductible	70% after deductible
	100% after deductible	70% after deductible
	100% after deductible	70% after deductible
	100% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	70% after deductible
	Cost-sharing for eligible diabetic devices will not exceed \$100 for a 30-day supply	
Diabetes Care Management Program (DCMP) – Digitally Monitored, includes telehealth consult for the A1C test	100%, No Deductible	No Benefits
	Continuous glucose monitor sprints are limited to three (3) per benefit period.	
DCMP – All Other Telehealth Consults	100%, No Deductible	No Benefits
Home Health Care	100% after deductible	70% after deductible
	Benefit Limit: 100 visits/benefit period, aggregate with Visiting Nurse	
Hospice	100% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment (9)	100% after deductible	70% after deductible
Private Duty Nursing	100% after deductible	70% after deductible
	Benefit Limit: 35 visits per benefit period	
Skilled Nursing Facility Care	100% after deductible	70% after deductible
	Benefit Limit: 60 visits per benefit period	
Transplant Services	100% after deductible	70% after deductible
Precertification/Authorization Requirements (10)	Yes	

Benefit	In Network	Out of Network
Prescription Drugs		
Prescription Drug Deductible Individual Family	None None	
Prescription Drug Program ⁽¹¹⁾ 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. Specialty Drugs are Limited to a 34-day Supply	Retail Drugs (34/35-90-day supply) Generic Drugs: \$15 / \$45 copayment Formulary Brand Drugs: \$50 / \$150 copayment Non-Formulary Brand Drugs: \$75 / \$225 copayment Cost-sharing for prescription insulin drugs will not exceed \$35 for a 30-day supply; Cost-sharing for eligible diabetic devices will not exceed \$100 for a 30-day supply Specialty Drugs (34- day supply) Specialty Formulary Drugs: \$50 Specialty Non-Formulary Drugs:\$75 Maintenance Drugs through Mail Order (90-day Supply) Generic Drugs: \$45 copayment Formulary Brand Drugs: \$150 copayment Non-Formulary Brand Drugs: \$225 copayment Cost-sharing for prescription insulin drugs will not exceed \$35 for a 30-day supply; Cost-sharing for eligible diabetic devices will not exceed \$100 for a 30-day supply	

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 Vendor. Additional services provided by a Designated Telemedicine Vendor 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 Outpatient Mental Health).
- 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) Unless otherwise provided for benefits for emergency ambulance services rendered by a non-network provider will be subject to the same cost-sharing amount, if any, that is applicable to network services. The member will be responsible for any amounts billed by the non-network provider for non-emergency ground and water ambulance services that are in excess of the amount that Highmark pays.
- 7) 20 visit maximum per event for combined Physical Therapy, Occupational Therapy and Spinal Manipulations.
- 8) After initial evaluation, Applied Behavioral Analysis 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). Treatment for Autism Spectrum Disorders does not reduce visit/day limit.
- 9) 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.
- 10) 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. Please note that certain outpatient procedures also require prior authorization. Be sure to verify that your provider is contacting MM&P for pre-certification. If this does not occur and it is later determined that your services are not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- 11) 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. Anti-Cancer medications orally administered or self-injected. Deductible, copayment, and coinsurance amounts for patient administered anti-cancer medications that are covered benefits are applied on no less favorable basis than for provider injected or intravenously administered anti-cancer medications.

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