SJM Health Plan — Effective 12/01/2026

HIGHMARK. | PPO Blue

Summary of PPO Blue Sharing $5,000 Rx B - Religious Exemption *Benefits*

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		
Benefit Period(1)	Contract Year	
Deductible (per Benefit Period) Individual Family	 $5,000 $10,000	 $10,000 $20,000
Coinsurance Member's Coinsurance obligation based on the Plan Allowance or Provider's Allowable Price	$0 after deductible	20% after deductible
Out-of-Pocket Maximums (Once met, Plan pays 100% for the rest of the benefit period) Individual Family	 None None	 $2,500 $5,000
Office/Clinic/Urgent Care Visits and Consultations		
Retail Clinic Visits	$20 copayment	20% after deductible
Primary Care Provider Office Visits	$20 copayment	20% after deductible
Specialist Office & Virtual Visits	$40 copayment	20% after deductible
Virtual Visit Provider Originating Site Fee	$0 after deductible	20% after deductible
Urgent Care Center Visits	$85 copayment	20% after deductible
Telemedicine Service(2)	$10 copayment	
Preventive Care(3)		
Routine Adult		
Physical Exams	$0 (deductible does not apply)	20% after deductible
Adult Immunizations	$0 (deductible does not apply)	20% after deductible
BRCA-Related Genetic Counseling and Genetic-Testing	$0 (deductible does not apply)	20% after deductible
Breast Cancer Screenings	Routine: $0 (deductible does not apply) Medically Necessary: $0 after deductible	20% after deductible
Colorectal Cancer Screening	$0 (deductible does not apply)	20% after deductible
Routine Gynecological Exams, including a Pap Test	$0 (deductible does not apply)	20% (deductible does not apply)
Diagnostic Services and Procedures	$0 (deductible does not apply)	20% after deductible
Routine Pediatric		
Physical Exams	$0 (deductible does not apply)	20% after deductible
Pediatric Immunizations	$0 (deductible does not apply)	20% (deductible does not apply)
Diagnostic Services and Procedures	$0 (deductible does not apply)	20% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	$0 after deductible	20% after deductible
Hospital Outpatient	$0 after deductible	20% after deductible
Maternity (non-preventive Facility & Professional Services) including dependent daughter	$0 after deductible	20% after deductible
Medical Care (including Inpatient Visits and Consultations)**/Surgical Expenses**	$0 after deductible	20% after deductible
Emergency Services		
Emergency Room Services	$125 copayment (waived if admitted)	
Ambulance (7)	$0 after deductible	$0 after in network deductible
Ambulance – Non-Emergency (8)	$0 after deductible	20% after deductible
Therapy and Habilitative and Rehabilitative Services		
Physical Medicine	$40 copayment	20% after deductible
- Limit	Limit: 20 visits/benefit period	
Respiratory Therapy	$0 after deductible	20% after deductible
Speech & Occupational Therapy	$40 copayment	20% after deductible

Benefit	Network	Out-of-Network
- Limit	Limit: 20 visits per therapy/benefit period Limit does not apply when rehabilitative or habilitative Speech Therapy services are prescribed for the treatment of childhood stuttering.	
Spinal Manipulations	$35 copayment	20% after deductible
- Limit	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	$0 after deductible	20% after deductible
Mental Health/Substance Abuse		
Inpatient	$0 after deductible	20% after deductible
Inpatient Detoxification/Rehabilitation	$0 after deductible	20% after deductible
Outpatient	$0 after deductible	20% after deductible
Other Services		
Allergy Extracts and Injections	$0 after deductible	20% after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Autism Spectrum Disorders (9)	$0 after deductible	20% after deductible
Dental Services Related to Accidental Injury	Not Covered	Not Covered
Diabetes Care Management Program (Digitally Monitored)	$0	Not Covered
	Continuous glucose monitor sprints are limited to three (3) per benefit period for Members diagnosed with type 2 diabetes	Not Covered
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET Scan, etc.)	$50 copayment after deductible (Was $0)	20% after deductible
Basic Diagnostic Services (Standard Imaging, Diagnostic Medical, Lab/Pathology, Allergy Testing)	$25 copayment after deductible (Was $0)	20% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	$0 after deductible	20% after deductible
Home Health Care	$0 after deductible	20% after deductible
- Limit	Limit: 90 visits/benefit period	
Hospice	$0 after deductible	20% after deductible
Infertility Counseling, Testing and Treatment(4)	$0 after deductible	20% after deductible
Private Duty Nursing	$0 after deductible	20% after deductible
- Limit	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	$0 after deductible	20% after deductible
- Limit	Limit: 100 days/benefit period	
Transplant Services	$0 after deductible	20% after deductible
Precertification Requirements(5)	YES	
Prescription Drugs		
Prescription Drug Deductible		
Individual Family	None None	
Prescription Drug Program(6) SensibleRx Complete *Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary with an Closed Benefit Design.*	**Retail Drugs (31/60/90-day Supply)** $10/$20/$30 generic copayment $50/$100/$150 formulary brand copayment **Maintenance Drugs through Mail Order (up to 90-day Supply)** $20 generic copayment $100 formulary brand copayment	

(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) Services must be performed by a Highmark approved telemedicine provider.
(3) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
(4) 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.
(5) 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.

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.

(6) The formulary is a listing of Prescription Drugs and Over-the-Counter Drugs selected by Highmark for their quality, safety and effectiveness. This listing is subject to periodic review and modification by Highmark or a designated committee of Physician or pharmacists. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under SensibleRx Complete, you are responsible for the payment differential when a generic drug is available and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

(7) Benefits for Emergency Ambulance Services rendered by an OutofNetwork Provider will be paid at the Network Services level and subject to the Deductible amount, if any, applicable to Network Services. The Member will not be responsible for any amounts billed by the OutofNetwork Provider that are in excess of the Plan Allowance for such Services.

(8) Benefits for Ambulance Services provided by air and rendered by an OutofNetwork Provider will be paid at the Network Services level and subject to the Deductible amount, if any, that is applicable to Network Services. The Member will not be responsible for any amounts billed by the OutofNetwork Provider that are in excess of the Plan Allowance for such Services.

(9) Certain Services for the treatment of Autism Spectrum Disorders including but not limited to diagnostic services, pharmacy care, psychiatric and psychological care, rehabilitative care and therapeutic care, are also described as Services covered under other benefits. When Members receive such services, they will be paid as specified in such other benefits. However, any visit limitations specified for such other benefits will not apply when those services are prescribed for the treatment of Autism Spectrum Disorders. Applied Behavioral Analysis for Services described as covered under the Contract only when received in connection with the Treatment of Autism Spectrum Disorders will be paid as set forth in the Summary of Benefits.