Benefits are administered by HealthNow Administrative Services (HNAS). HNAS uses the Highmark Network of providers for your coverage.

THE ROMAN CATHOLIC DIOCESE OF ALTOONA-JOHNSTOWN

Lay Employees QHDHP $2,000 Benefit Summary

Benefit	Network	Out-of-Network
General Provisions		
Effective Date: April 1, 2023	Contract year: April 1, 2023 – March 31, 2024	
Deductible (1) (per benefit period) Individual Family	 $2,000 $4,000	 $4,000 $8,000
Plan Pays – payment based on the plan allowance	100% after deductible	50% after deductible
Out-of-Pocket Limit (Includes medical deductible and coinsurance) (2) Individual Family	 $2,000 $4,000	 Not Applicable Not Applicable
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $2,000 $4,000	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after deductible	50% after deductible
Primary Care Provider Office Visits	100% after deductible	50% after deductible
Specialist Office Visits & Virtual Visits	100% after deductible	50% after deductible
Urgent Care Center Visits	100% after deductible	50% after deductible
Preventive Care		
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% after deductible
Mammograms, annual routine	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
Emergency Services		
Emergency Room Services	100% after deductible	
Ambulance – Emergency	100% after deductible	
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) excluding dependent daughter	100% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	50% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after deductible	50% after deductible
Respiratory Therapy	100% after deductible	50% after deductible
Speech Therapy	100% after deductible	50% after deductible
Occupational Therapy	100% after deductible	50% after deductible
Spinal Manipulations	100% after deductible Limit: 25 visits/benefit period	50% after deductible
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	100% after deductible	50% after deductible
Outpatient Substance Abuse Services	100% after deductible	50% after 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 benefits summary.

Highmark 10527376/10527377
HealthNow T67HDHPPPO(F)

Benefit	Network	Out-of-Network
Other Services		
Allergy Extracts and Injections	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 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
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	50% after deductible
Home Health Care	100% after deductible	50% after deductible
Hospice	100% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment	Not Covered	Not Covered
Private Duty Nursing	100% after deductible	50% after deductible
Skilled Nursing Facility Care	100% after deductible	50% after deductible
Transplant Services	100% after deductible	50% after deductible
Precertification/Authorization Requirements (3)	Yes	

Summary of Prescription Drug Coverage

Prescription Drugs	
Prescription Drug Deductible Employee Only Family	 Integrated with Medical Integrated with Medical
Prescription Drug Program EmpiRX is the administrator of the prescription drug plan. Your plan uses the Total Care Plus Formulary. More information about prescription drug coverage is available at www.empirxhealth.com	**Retail Drugs (up to 34/60/90-day Supply)** 100% after deductible **Specialty Medications (up to 30-day Supply)** 100% after deductible **Mail Order (up to 90-day Supply)** 100% after deductible

(1) Your family plan has a non-embedded Deductible, which means that, any covered member and any combination of covered family members can meet the family Deductible before Covered Services are paid for any member on the plan. The individual Deductible does not apply if you are enrolled in family coverage.
(2) The out-of-pocket limit is non-embedded. If you are enrolled as a single participant in the Plan, the single out-of-pocket limit applies. If you are enrolled as a family in the Plan, the family out-of-pocket limit applies. When an individual or family reaches the annual limit, the Plan pays 100% of additional covered expenses for the rest of the benefit year.
(3) You are required to call the phone number on your ID card to obtain precertification prior to receiving certain benefits (for a detailed list of services requiring precertification please refer to the Summary Plan Description). When the required review procedures are followed, your benefits will be unaffected. Failure to comply with the required review procedures will result in a penalty being applied to eligible expenses that does not apply to your out-of-pocket limit.
(a) When services are received from a participating provider, precertification will be obtained by the health care provider. If certification is not received, the benefit will be reduced by 100%.
(b) When services are received from a non-participating provider, you are responsible to obtain precertification. If certification is not received, benefits will be reduced by 100%, and the penalty you pay does not apply to your out-of-pocket limit.