

# Interim

## HEALTHCARE®

2022 - 2023 Highmark Plan (Effective 9/1/22)				Summary of Changes
Benefit Summary	Current (DISCONTINUED) Com. Blue Flex PPO \$2,000 80/70/50	Buy-Up (Option 2) Performance Blue PPO \$2,000 80/50 \$25/\$50	Core (Option 4) Performance Blue PPO \$5,000 80/50 \$25/\$25	
<b>Deductible</b>				< Current plan is discontinued as of 8/31/22 and replaced with two new plan options < Community Blue network changes to Performance Flex Blue network (same providers) < The Core plan offers a higher deductible but with lower co-pays and lower premiums
In Network Enhanced	\$2,000 / \$4,000	\$2,000 / \$4,000	\$5,000 / \$10,000	
<del>In Network Standard</del>	<del>\$4,000 / \$8,000</del>			< Current plan changes to the Buy-Up minus the middle "Standard" tier
Out of Network	\$9,000 / \$18,000	\$9,000 / \$18,000	\$10,000 / \$20,000	
<b>Co-insurance</b>				
In Network - Enhanced	80% / 20%	80% / 20%	80% / 20%	
<del>In Network Standard</del>	<del>70% / 30%</del>			
Out of Network	50% / 50%	50% / 50%	50% / 50%	
<b>Out of Pocket Limit - Coinsurance</b>				
In Network - Enhanced	\$1,500 / \$3,000	\$1,500 / \$3,000	\$2,000 / \$4,000	
<del>In Network Standard</del>	<del>\$1,850 / \$3,700</del>			
Out of Network	\$6,000 / \$12,000	\$3,000 / \$6,000	\$4,000 / \$8,000	< Out of Network Out of Pocket Maximum amount decreases
<b>Total Out of Pocket Maximum</b>				
In-Network	\$8,700 / \$17,400	\$8,700 / \$17,400	\$8,700 / \$17,400	
Out of Network	n/a	n/a	n/a	
<b>In-Network Benefits</b>				
<b>Primary Care Office Visit</b>	(E) \$25 copay <del>(\$) \$50 copay</del>	\$25 copay	\$25 copay	
<b>Specialty Care Office Visits</b>	(E) \$25 copay <del>(\$) \$50 copay</del>	\$50 copay	\$25 copay	< Change to co-pay amount
<b>Urgent Care Visit</b>	(E) \$50 copay <del>(\$) \$100 copay</del>	\$75 copay	\$50 copay	< Change to co-pay amount
<b>Emergency Room Visit</b>	\$250 copay	\$250 copay	\$250 copay	
<b>Inpatient Hospitalization</b>	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance	
<b>Outpatient Lab, X-rays &amp; Diag</b>	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance	
<b>Outpatient Major Diag - CT, MRI, Etc.</b>	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance	
<b>Outpatient Rehab Therapy (PT, OT, ST)</b>	(E) \$25 copay <del>(\$) \$50 copay</del> (Limited visits)	\$50 copay (Limited visits)	\$25 copay (Limited visits)	< Change to co-pay amount
<b>Outpatient Surgery</b>	Deductible & coinsurance	Deductible & coinsurance	Deductible & coinsurance	
<b>Prescription Drugs</b>				
30 Day Supply (Retail)	\$15 / \$25 / \$40	\$15 / \$25 / \$40	\$15 / \$25 / \$40	< No change to Rx design
90 Day Supply (Retail)	\$45 / \$75 / \$120	\$45 / \$75 / \$120	\$45 / \$75 / \$120	
90 Day Supply (Mail Order)	\$30 / \$50 / \$80	\$30 / \$50 / \$80	\$30 / \$50 / \$80	
<b>Employee Rates</b>	Employee Only	\$49.85 / \$24.92	\$49.85 / \$24.92	\$31.95 / \$15.97
<b>Bi-Weekly / Weekly</b>	Employee + Spouse	\$354.00 / \$177.00	\$354.00 / \$177.00	\$295.00 / \$147.50
	Employee + Child(ren)	\$354.00 / \$177.00	\$354.00 / \$177.00	\$295.00 / \$147.50
	Employee + Family	\$382.00 / \$191.00	\$382.00 / \$191.00	\$314.11 / \$157.06
				< No rate change for the Buy-Up plan. Lower premiums for the Core plan.

Hylant Group Disclaimer: The abbreviated outlines of benefits used throughout this document are not intended to express any legal opinion as to the nature of coverage. They are only visuals to a basic understanding of coverages and do not detail all the contract terms nor do they alter any contract conditions. Please read your contract for specific coverages, limitations, and exclusions and call us with questions. **UW reserves the right to revise the rates should changes to demographics be made from submitted applications.**