Summary of PPO Blue $0 100/80 Platinum *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	 $0 $0	 $500 $1,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes deductible, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period.) Individual Family	 $4,000 $8,000	 $8,000 $16,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $20 copay	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $20 copay	80% after deductible
Specialist Office & Virtual Visits	100% after $35 copay	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $40 copay, the copayment, if any, does not apply to urgent care services prescribed for the treatment of mental illness or substance abuse	80% after deductible
Preventive Care(2)		
Routine Adult		
Adult immunizations	100%	80% after deductible
Colorectal cancer screening	100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
Mammograms(annual routine)	100%	80% after deductible
Mammograms (medically necessary)	100%	80% after deductible
Physical exams	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100%	80%
Routine adult vision Screening	100%	Not Covered
Routine Pediatric		
Diagnostic services and procedures	100%	80% after deductible
Pediatric immunizations	100%	80%
Physical exams	100%	80% after deductible
Pediatric Vision(3) - **Davis Vision National Network**		
Exam (including dilation, as professionally indicated)	100%	Not Covered
Pediatric frame selection	100%	Not Covered
Standard eyeglass lenses (per pair)	100%	Not Covered
Contact Lens Benefit (in lieu of eyeglasses)	100%	Not Covered
Evaluation, Fitting & Follow-up Care	100%	Not Covered
Collection Contact Lenses (Disposable; Planned Replacement)	100%	Not Covered
Non-Collection Contact Lenses: Materials Allowance	$150 discounted price	Not Covered
Evaluation, Fitting & Follow-up Care – Standard lens Types and Specialty Lens Types	Not Covered	Not Covered
Pediatric Dental(3) - United Concordia Advantage Network		
Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants)	100%	Not Covered
Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings))	50%	Not Covered
Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.))	50%	Not Covered
Orthodontics(4) (Medically necessary with prior approval)	50%	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient (Non-Surgical)	100% after deductible	80% after deductible
Outpatient Surgery (8)	100% after deductible	80% after deductible
Maternity (non-preventive facility) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)**/Surgical Expenses**	100% after deductible	80% after deductible
Emergency Services		
Emergency Room Services	100% after $150 copay (waived if admitted)	
Ambulance (9)	100% after in-network deductible	
Ambulance – Non-Emergency (10)	100% after deductible	80% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Medicine (Rehabilitative and Habilitative)	100% after $35 copay	80% after deductible

Benefit	Network	Out-of-Network
Physical Medicine – Benefit Maximum - Combined with Occupational Therapy	Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to therapy services for the treatment of a Mental Health or Substance Abuse diagnosis	
Respiratory Therapy	100% after deductible	80% after deductible
Speech Therapy (Rehabilitative and Habilitative)	100% after $35 copay	80% after deductible
Speech Therapy- Benefit Maximum	Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to therapy services for the treatment of a Mental Health or Substance Abuse diagnosis	
Occupational Therapy (Rehabilitative and Habilitative)	100% after $35 copay	80% after deductible
Occupational Therapy – Benefit Maximum - Combined with Physical Therapy	Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to therapy services for the treatment of a Mental Health or Substance Abuse diagnosis	
Spinal Manipulations	100% after $35 copay	80% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health/Substance Abuse		
Inpatient	100% after deductible	80% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	80% after deductible
Outpatient Includes Virtual Behavioral Health Visits	100% after $35 copay	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Artificial Insemination	100% after deductible	80% after deductible
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diabetes Care Management Program (Digitally Monitored)	100%	Not Covered
	Continuous glucose monitor sprints are limited to three (3) per benefit period	
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after $75 copay, the copayment, if any, does not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical)	100% after $35 copay, the copayment, if any, does not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse	80% after deductible
Lab/Pathology	100% after $35 copay, the copayment, if any, does not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse	80% after deductible
Durable Medical Equipment	100% after deductible	80% after deductible
Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	Limit: 60 visits/benefit period	
House Call Program	100%	Not Covered
	Limited to one (1) per benefit period	
Hospice	100% after deductible	80% after deductible
	Respite care limit of 7 days every 6 months	
Infertility Counseling, Testing and Treatment(5)	100% after deductible	80% after deductible
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	Limit: 120 days/benefit period	
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements(6)	YES	
Prescription Drugs		
Prescription Drug Deductible Individual Family	None None	
Prescription Drug Program(7) Soft Mandatory Generic *Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the HCR Comprehensive Formulary with an Incentive Benefit Design.*	**Retail Drugs (31/60/90-day Supply)** $3 / $6 / $9 low cost generic copay -- $10 / $20 / $30 standard generic copay $50 / $100 / $150 formulary brand copay $85 / $170 / $255 non-formulary copay 20% formulary specialty coinsurance -- $350 Maximum (31-day supply-Retail) 30% non-formulary specialty coinsurance -- $500 Maximum (31-day supply-Retail) **Maintenance Drugs through Mail Order (90-day Supply)** $3 low cost generic copay -- $10 standard generic copay $100 formulary brand copay $170 non-formulary brand copay 20% formulary specialty coinsurance -- $700 Maximum (Mail Order) 30% non-formulary specialty coinsurance -- $1000 Maximum (Mail Order)	

To access more information about the drug formulary, including tiering, please go to https://www.highmark.com/content/dam/digital-marketing/en/highmark/highmarkdotcom/pdfs/quality-assurance/CS204330_NCQAPreSale_BRO_BCBS_R2.pdf or for a paper copy, call 1-855-873-4106.

(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 are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
(3) Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.
(4) A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality. Prior approval is required. See your benefit booklet for more details.
(5) 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.
(6) 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.
(7) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider 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.
(8) Refers to outpatient surgical procedure provided in a hospital or ambulatory facility setting.
(9) 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.
(10) 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.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Coverage Advantage or Highmark Health Insurance Company, all of which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement. To find more information about Highmark's benefits and operating procedures, such as using network providers, please go to; https://www.highmark.com/content/dam/digital-marketing/en/highmark/highmarkdotcom/pdfs/quality-assurance/CS204330_NCQAPreSale_BRO_BCBS_R2.pdf or for a paper copy, call 1-855-873-4106.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition.
Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito.
Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung.
Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。
ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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