

Summary of Flex EPO \$500 a Community Blue Plan Benefits

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers who offer enhanced benefits coverage, you will pay less out of pocket. 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
	Enhanced Value	Standard Value	
General Provisions			
Benefit Period ⁽¹⁾	Contract Year		
Deductible (per benefit period) (All in-network services are credited to both the standard and the enhanced deductibles.) Individual Family	\$500 \$1,000	\$1,000 \$2,000	Not Covered Not Covered
Plan Pays – payment based on the plan allowance	80% after deductible	70% after deductible	Not Covered
Out-of-Pocket Limit (Includes deductible, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period.) Individual Family	\$4,150 \$8,300		Not Covered Not Covered
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	80% after enhanced deductible		Not Covered
Primary Care Provider Office Visits & Virtual Visits	80% after deductible	70% after deductible	Not Covered
Specialist Office & Virtual Visits	80% after deductible	70% after deductible	Not Covered
Virtual Visit Originating Site Fee	80% after deductible	70% after deductible	Not Covered
Urgent Care Center Visits	80% after enhanced deductible		Not Covered
Telemedicine Services ⁽²⁾	80% after enhanced deductible		
Preventive Care ⁽³⁾			
Routine Adult			
Adult immunizations	100% (deductible does not apply)		Not Covered
Colorectal cancer screening	100% (deductible does not apply)		Not Covered
Diagnostic services and procedures	100% (deductible does not apply)		Not Covered
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)		Not Covered
Physical exams	100% (deductible does not apply)		Not Covered
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)		Not Covered
Routine adult vision exam	100% (deductible does not apply)		Not Covered
Routine Pediatric			
Diagnostic services and procedures	100% (deductible does not apply)		Not Covered
Pediatric immunizations	100% (deductible does not apply)		Not Covered
Physical exams	100% (deductible does not apply)		Not Covered
Pediatric Vision ⁽⁴⁾ - Davis Vision National Network			
Exam (including dilation, as professionally indicated)	100% (deductible does not apply)		Not Covered
Pediatric frame selection	100% (deductible does not apply)		Not Covered
Standard eyeglass lenses (per pair)	100% (deductible does not apply)		Not Covered
Pediatric Dental ⁽⁴⁾ - United Concordia Advantage Network			
Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants)	100% (deductible does not apply)		Not Covered
Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings))	50% (deductible does not apply)		Not Covered
Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.))	50% (deductible does not apply)		Not Covered
Orthodontics ⁽⁵⁾ (Medically necessary with prior approval. Waiting limits apply.)	50% (deductible does not apply)		Not Covered
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Inpatient	80% after deductible	70% after deductible	Not Covered
Hospital Outpatient	80% after deductible	70% after deductible	Not Covered
Maternity (non-preventive facility & professional services. Includes dependent daughter.)	80% after deductible	70% after deductible	Not Covered
Medical Care (including inpatient visits and consultations)/ Surgical Expenses	80% after deductible	70% after deductible	Not Covered
Emergency Services			
Emergency Room Services	80% after enhanced deductible		
Ambulance	80% after enhanced deductible		
Ambulance – Non-Emergency	80% after deductible		Not Covered
Therapy, Rehabilitative and Habilitative Services			
Physical Medicine (Rehabilitative and Habilitative)	80% after deductible	70% after deductible	Not Covered
	Limit: 30 combined rehab/habilitative visits/benefit period		
Respiratory Therapy	80% after deductible	70% after deductible	Not Covered
Speech & Occupational Therapy (Rehabilitative and Habilitative)	80% after deductible	70% after deductible	Not Covered
	Limit: 30 combined rehab/habilitative visits per therapy/benefit period		

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Spinal Manipulations	80% after deductible	70% after deductible Limit: 20 visits/benefit period	Not Covered
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	70% after deductible	Not Covered
Mental Health/Substance Abuse			
Inpatient	80% after enhanced deductible		Not Covered
Inpatient Detoxification/Rehabilitation	80% after enhanced deductible		Not Covered
Outpatient Includes Virtual Behavioral Health Visits	80% after enhanced deductible		Not Covered
Other Services			
Allergy Extracts and Injections	80% after deductible	70% after deductible	Not Covered
Assisted Fertilization Procedures		Not Covered	
Dental Services Related to Accidental Injury		Not Covered	
Diagnostic Services			
<i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	80% after deductible	70% after deductible	Not Covered
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	70% after deductible	Not Covered
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	70% after deductible	Not Covered
Home Health Care	80% after deductible	70% after deductible	Not Covered
		Limit: 90 visits/benefit period	
Hospice	80% after deductible	70% after deductible	Not Covered
Infertility Counseling, Testing and Treatment (6)	80% after deductible	70% after deductible	Not Covered
Private Duty Nursing		80% after deductible	Not Covered
		Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	80% after deductible	70% after deductible	Not Covered
		Limit: 120 days/benefit period	
Transplant Services	80% after deductible	70% after deductible	Not Covered
Precertification Requirements (7)		YES	
Prescription Drugs			
Prescription Drug Deductible Individual Family		Combined with medical Combined with medical	
Prescription Drug Program (8) Soft Mandatory Generic <i>Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i> <i>Your plan uses the HCR Comprehensive Formulary with an Open Benefit Design.</i>		Retail Drugs (31/60/90-day Supply) Retail Generic: 30% after deductible Retail Brand: 30% after deductible Retail Non-Formulary: 30% after deductible Maintenance Drugs through Mail Order (90-day Supply) Mail Order Generic: 30% after deductible Mail Order Brand: 30% after deductible Mail Order Non-Formulary: 30% after deductible	

- (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 provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health / Substance Abuse benefit.
- (3) Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
- (4) Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.
- (5) 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. 12 month waiting period required. See your benefit booklet for more details.
- (6) 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.
- (7) 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.
- (8) 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.

Highmark Blue Shield (Highmark) is an independent licensee of the Blue Cross and Blue Shield Association. Insurance may be provided by Highmark Health Insurance Company or Highmark Benefits Group. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4108.

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

We are committed to providing outstanding services for our applicants and members. If you require special assistance, including accommodations for disabilities or limited English proficiency, please call us at 1-888-269-8412 to request these free services (TTY/TDD users may call 711).

Estamos comprometidos a ofrecer servicios excepcionales a nuestros solicitantes y miembros. Si usted necesita ayuda especial, incluyendo acomodaciones para discapacidades o dominio limitado del inglés, por favor llámenos al 1-888-510-1084 para solicitar estos servicios gratuitos. (TTY/TDD: 711)

我們致力於為我們的申請人和會員們提供卓越的服務。如果您需要特殊協助，包括殘障或英語能力有限，請致電1-888-510-1084來要求這些免費服務。(TTY/TDD: 711)

May pananagutan kaming magbigay ng bukod-tanging mga serbisyo para sa aming mga aplikante at mga miyembro. Kung kailangan mo ng espesyal na tulong, kabilang ang mga akomodasyon para sa mga kapansanan o limitadong kahusayan sa wikang Ingles, mangyaring tawagan kami sa 1-888-510-1084 para hilingin ang mga libreng serbisyo ng ito. (TTY/TDD: 711)

Nihinaanish niizhónigo bee nihiká' adiilwołígíí binahjĩ' ts'ídá yéego biidiilkaal, nihí naaltsoos nidahon'ígíí doó Bee Atah ídlínígíí nihit hada'dit'éhígíí nihá. Bilagáana bizaad doo hazhó'ó bik'i' diitiihgó, áká'a'ayeed nínízingo, béésh bee hane'é bikáá', éí éí 1-888-510-1084, t'áá jíík'eh níká' idooowolgo át'é. T'ááyó nijéékałgo éí TTY chodayool'ínígíí 711 nídlígis doó bich'i' hółne' dooleet, díí éí t'áá jíík'eh níká' idooowol.