Summary of Premier Balance PPO $1000 A a Community Blue Flex 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	 $1,000 $2,000	 $2,000 $4,000	 $6,000 $12,000
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible	50% 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	 $3,500 $7,000		 $10,500 $21,000
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after $20 copayment	100% after $60 copayment	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $20 copayment	100% after $60 copayment	50% after deductible
Specialist Office & Virtual Visits	100% after $40 copayment	100% after $90 copayment	50% after deductible
Virtual Visit Originating Site Fee	100% after deductible	70% after deductible	50% after deductible
Urgent Care Center Visits	100% after $65 copayment	100% after $100 copayment	50% after deductible
Telemedicine Services(2)	100% after $15 copayment		
Preventive Care(3)			
Routine Adult			
Adult immunizations	100% (deductible does not apply)		50% after deductible
Colorectal cancer screening	100% (deductible does not apply)		50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)		50% after deductible
Physical exams	100% (deductible does not apply)		50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)		50% (deductible does not apply)
Routine adult vision exam	100% (deductible does not apply)		Not Covered
Routine Pediatric			
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Pediatric immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Physical exams	100% (deductible does not apply)		50% after deductible
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	100% after deductible	70% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services. Includes dependent daughter.)	100% after deductible	70% after deductible	50% after deductible

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Medical Care (including inpatient visits and consultations)**/Surgical Expenses**	100% after deductible	70% after deductible	50% after deductible
Emergency Services			
Emergency Room Services	100% after $150 copayment (waived if admitted)		
Ambulance	100% after enhanced deductible		
Ambulance – Non-Emergency	100% after enhanced deductible		
Therapy, Rehabilitative and Habilitative Services			
Physical Medicine (Rehabilitative and Habilitative)	100% after $40 copayment	100% after $90 copayment	50% after deductible
	Limit: 30 combined rehab/habilitative visits/benefit period		
Respiratory Therapy	100% after deductible	70% after deductible	50% after deductible
Speech & Occupational Therapy (Rehabilitative and Habilitative)	100% after $40 copayment	100% after $90 copayment	50% after deductible
	Limit: 30 combined rehab/habilitative visits per therapy/benefit period		
Spinal Manipulations	100% after $40 copayment	100% after $90 copayment	50% after deductible
	Limit: 20 visits/benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible	50% after deductible
Mental Health/Substance Abuse			
Inpatient	100% after enhanced deductible		50% after deductible
Inpatient Detoxification/Rehabilitation	100% after enhanced deductible		50% after deductible
Outpatient **Includes Virtual Behavioral Health Visits**	100% after $40 copayment		50% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	Not Covered		
Diagnostic Services			
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after $100 copayment	100% after $200 copayment	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after $40 copayment	100% after $90 copayment	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	70% after deductible	50% after deductible
Home Health Care	100% after deductible	70% after deductible	50% after deductible
	Limit: 90 visits/benefit period		
Hospice	100% after deductible	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment(6)	100% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	70% after deductible	50% after deductible
	Limit: 240 hours/benefit period		
Skilled Nursing Facility Care	100% after deductible	70% after deductible	50% after deductible
	Limit: 120 days/benefit period		
Transplant Services	100% after deductible	70% after deductible	50% after deductible
Precertification Requirements(7)	YES		
Prescription Drugs			
Prescription Drug Deductible Individual Family	None None		
Prescription Drug Program(8) 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 copayment --- $8 /$16 / $24 standard generic copayment $40 / $80 / $120 formulary brand copayment $70 / $140 / $210 non-formulary copayment 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)** $8 low cost generic copayment ---$20 standard generic copayment $100 formulary brand copayment $175 non-formulary brand copayment 20% formulary specialty coinsurance -- $875 Maximum (Mail Order) 30% non-formulary specialty coinsurance- $1250 Maximum (Mail Order)		

(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.

**The terms "enhanced value" and "standard value" are not descriptors of the provider's ability. This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.*

(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) 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.

Highmark Blue Cross Blue Shield (Highmark), is an independent licensee of Blue Cross and Blue Shield Association. Insurance may be provided by Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Care Advantage. 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, call1-855-873-4106.

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 1-800-876-7639 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-tangingmga 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 serbisyong ito. (TTY/TDD: 711)

Nihinaanish niizhónígo bee nihiká' adiilwołígíí binahjí' ts'ídá yéego bidiilkaal, nihí naaltsoos nidahonłhígíí doóBee Atah ídlínígíí nihił hada'díť'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' idoowołgo át'é. T'ááyó nijéékałgo éí TTY chodayooł'ínígíí 711 nídíígis dóó bich'į' hólne' dooleeł, díí éí t'áá jíík'eh níká' idoowoł.