Summary of Premier Balance PPO $2000 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	 $2,000 $4,000	 $3,000 $6,000	 $9,000 $18,000
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	 $3,450 $6,900		 $10,350 $20,700
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after $20 Copay	100% after $60 Copay	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $20 Copay	100% after $60 Copay	50% after deductible
Specialist Office & Virtual Visits	100% after $40 Copay	100% after $90 Copay	50% after deductible
Virtual Visit Originating Site Fee	100% after deductible	70% after deductible	50% after deductible
Urgent Care Center Visits	100% after $65 Copay	100% after $100 Copay	50% after deductible
Telemedicine Services(2)	100% after $15 Copay		Not Covered
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)	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Mammograms (medically necessary)	100% (deductible does not apply)	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 Screening	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 $200 Copay (waived if admitted)		
Ambulance	100% after enhanced deductible		
Ambulance – Non-Emergency	100% after enhanced deductible	100% after enhanced deductible	100% after enhanced deductible
Therapy, Rehabilitative and Habilitative Services			
Physical Medicine (Rehabilitative and Habilitative)	100% after $40 Copay	100% after $90 Copay	50% after deductible
Physical Medicine – Benefit Maximum	Limit: 30 rehabilitative and 30 habilitative visits/benefit period		
Respiratory Therapy	100% after deductible	70% after deductible	50% after deductible
Speech Therapy (Rehabilitative and Habilitative)	100% after $40 Copay	100% after $90 Copay	50% after deductible
Speech Therapy – Benefit Maximum	Limit: 30 rehabilitative and 30 Habilitative visits /benefit period Combined with Occupational Therapy		
Occupational Therapy (Rehabilitative and Habilitative)	100% after $40 Copay	100% after $90 Copay	50% after deductible
Occupational Therapy – Benefit Maximum	Limit: 30 rehabilitative and 30 Habilitative visits /benefit period Combined with Speech Therapy		
Spinal Manipulations	100% after $40 Copay	100% after $90 Copay	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 Copay		50% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures (limited to artificial insemination)	100% after deductible	70% after deductible	50% after deductible
Dental Services Related to Accidental Injury	100% after deductible	70% after deductible	50% after deductible
Diagnostic Services			
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after $150 Copay	100% after $250 Copay	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after $40 Copay	100% after $90 Copay	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: 60 visits/benefit period		
Hospice	100% after deductible	70% after deductible	50% after deductible
	Respite care limit of 7 days every 6 months		
Infertility Counseling, Testing and Treatment(6)	100% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	Not Covered	Not Covered	Not Covered
Private Duty Nursing – Benefit Limits	N/A		
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		

**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.*

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
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 Copay --- $10 /$20 / $30 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)** $8 low cost generic Copay -- $25 standard generic Copay $125 formulary brand Copay $213 non-formulary brand Copay 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.
(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.

Discrimination is Against the Law

The Plan 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 Plan 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 Plan 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 Plan 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 Plan:

- 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 Plan 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.

If you speak English, language assistance services, free of charge, are available to you. Call 1-800-876-7639.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-800-876-7639.

如果您说中文，可向您提供免费语言协助服务。 請致電 1-800-876-7639.

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Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-800-876-7639.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-800-876-7639.

Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du 1-800-876-7639 uffrufe.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-800-876-7639 로 전화.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-800-876-7639.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-800-876-7639.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-800-876-7639.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-800-876-7639 નંબર પર ફોન કરો.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-800-876-7639.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.

បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ការហៅ 1-800-876-7639។

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-800-876-7639.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-800-876-7639.

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。 1-800-876-7639 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-800-876-7639 .

Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-800-876-7639.