

Summary of Premier Balance PPO \$2000 A 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 | \$2,000 | \$4,000 |
| Family | \$4,000 | \$8,000 |
| 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 | \$6,100 | \$12,200 |
| Family | \$12,200 | \$24,400 |
| Office/Clinic/Urgent Care Visits | | |
| Retail Clinic Visits & Virtual Visits | 100% after \$30 Copay | 80% after deductible |
| Primary Care Provider Office Visits & Virtual Visits | 100% after \$30 Copay | 80% after deductible |
| Specialist Office & Virtual Visits | 100% after \$60 Copay | 80% after deductible |
| Virtual Visit Originating Site Fee | 100% after deductible | 80% after deductible |
| Urgent Care Center Visits | 100% after \$75 Copay | 80% after deductible |
| Telemedicine Services ⁽²⁾ | 100% after \$15 Copay | Not Covered |
| Preventive Care ⁽³⁾ | | |
| 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 ⁽⁴⁾ - | | |
| 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 |
| Pediatric Dental ⁽⁴⁾ - | | |
| 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 ⁽⁵⁾ (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 | 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 \$300 Copay (waived if admitted) | |
| Ambulance | 100% after in-network deductible | |
| Ambulance – Non-Emergency | 100% after deductible | 80% after deductible |
| Therapy, Rehabilitative and Habilitative Services | | |
| Physical Medicine (Rehabilitative and Habilitative) | 100% after \$60 Copay | 80% after deductible |
| Physical Medicine – Benefit Maximum | Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to Habilitative 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 \$60 Copay | 80% after deductible |
| Speech Therapy- Benefit Maximum | Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to Habilitative services for the treatment of a Mental Health or Substance Abuse diagnosis Combined with Occupational Therapy | |
| Occupational Therapy (Rehabilitative and Habilitative) | 100% after \$60 Copay | 80% after deductible |
| Occupational Therapy – Benefit Maximum | Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to Habilitative services for the treatment of a Mental Health or Substance Abuse diagnosis Combined with Speech Therapy | |

| (8) Benefit | Network | Out-of-Network |
|---|---|-----------------------|
| Spinal Manipulations | 100% after \$60 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 \$60 Copay | 80% after deductible |
| Other Services | | |
| Allergy Extracts and Injections | 100% after deductible | 80% after deductible |
| Assisted Fertilization Procedures (limited to artificial insemination) | 100% after deductible | 80% after deductible |
| Dental Services Related to Accidental Injury | 100% after deductible | 80% after deductible |
| Diagnostic Services | | |
| Advanced Imaging (MRI, CAT, PET scan, etc.) | 100% after \$300 Copay | 80% after deductible |
| Basic Diagnostic Services (standard imaging, diagnostic medical) | 100% after \$60 Copay | 80% after deductible |
| Lab/Pathology | 100% after \$60 Copay | 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 | |
| Hospice | 100% after deductible | 80% after deductible |
| | Respite care limit of 7 days every 6 months | |
| Infertility Counseling, Testing and Treatment (6) | 100% after deductible | 80% after deductible |
| | 100% after deductible | 80% after deductible |
| Skilled Nursing Facility Care | | |
| | Limit: 120 days/benefit period | |
| Transplant Services | 100% after deductible | 80% after deductible |
| Precertification Requirements (7) | YES | |
| Prescription Drugs | | |
| Prescription Drug Deductible Individual Family | None None | |
| 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 Incentive Benefit Design.</i> | Retail Drugs | |
| | \$3 / \$6 / \$9 low cost generic Copay --- \$15 /\$30 / \$45 generic Copay | |
| | \$55 / \$110 / \$165 formulary brand Copay | |
| | \$90 / \$180 / \$270 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 -- \$15 standard generic Copay | |
| | \$110 formulary brand Copay | |
| | \$180 non-formulary brand Copay | |
| | 20% formulary specialty coinsurance -- \$700 Maximum (Mail Order) | |
| 30% non-formulary specialty coinsurance- \$1000 Maximum (Mail Order) | | |

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 accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4106.

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.

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 serbisyonang 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 المساعدة 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.