## Summary of Flex PPO PA Mountains Healthcare Region \$500/\$1500 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 o

will pay less out o f 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.

		twork	Out-of-Network
	Enhanced Value	Standard Value	
	General Provision	Contract Year	
Deductible (per benefit period) (All in-network			
services are credited to both the standard and the			
enhanced deductibles.)	¢гоо	¢1 500	¢4.500
Individual Family	\$500 \$1,000	\$1,500 \$3,000	\$4,500 \$9,000
· · · · · · · · · · · · · · · · · · ·	100% after		
Plan Pays – payment based on the plan allowance	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.)	¢7 250		\$22,050
Family	\$1 \$1	7,350 4,700	\$44,100
	fice/Clinic/Urgent Car	e Visits	<b>*</b> · · · <b>,</b> · · · ·
Retail Clinic Visits	100% afte	er \$30 Copay	50% after deductible
Primary Care Provider Office Visits	100% after \$20	100% after \$50	50% after deductible
	Copay 100% after \$45	Copay 100% after \$75	
Specialist Office & Virtual Visits	Copay	Copay	50% after deductible
Virtual Visit Originating Site Fee	100% after	70% after deductible	50% after deductible
0 0	deductible		
Urgent Care Center Visits		er \$75 Copay	50% after deductible
Telemedicine Service(2)		er \$15 Copay	Not Covered
Routine Adult	Preventive Care(3	3)	
Adult immunizations	1	00%	50% after deductible
Colorectal cancer screening		00%	50% after deductible
Diagnostic services and procedures	100%		50% after deductible
Mammograms ( annual routine)	100%	100%	50% after deductible
Mammograms (medically necessary)	100%	100%	50% after deductible
Physical exams		00%	50% after deductible
Routine gynecological exams, including a Pap Test	1	00%	50%
Routine adult vision screening		100%	
Routine Pediatric Diagnostic services and procedures	4	00%	50% after deductible
Pediatric immunizations		00%	50% after deductible 50%
Physical exams		00%	50% after deductible
Pediatric Vision(4) -		0070	
Davis Vision National Network			
Exam (including dilation, as professionally			
indicated)	100%		Not Covered
Pediatric frame selection	100%		Not Covered
Standard eyeglass lenses (per pair)	1	00%	Not Covered
Pediatric Dental(4) -			
United Concordia Advantage Network			
Exam and Cleanings	1	00%	Not Covered
Basic Services (Fluoride treatments, sealants,	Ę	50%	Not Covered
consultations) Major Services (Radiographs (all x-rays), space			
maintainers, amalgam restorations (metal fillings),			
resin based composite fillings (white fillings),	Ę	50%	Not Covered
crowns, inlays, onlays, crown repair, endodontic			
therapy (root canals, etc.))			
Orthodontics(5) (Medically necessary with prior approval.)	5	50%	Not Covered
	ical/Surgical Expense	s (including maternity)	
Hospital Inpatient	100% after	70% after deductible	50% after deductible
เงอุหาเล่า แท้ละเอเน	deductible		
Hospital Outpatient	100% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility services Includes	100% after	700/ (/ ) )	
dependent daughter.)	deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and	100% after	70% after deductible	50% after deductible
consultations)/Surgical Expenses	deductible		
	Emergency Servic		
Emergency Room Services		00% after \$225 Copay (waive	ad if admitted)

Enhanced         Standard           Value         Value         70% after deductible         50% after deductible           Inputance – Non-Emergency         100% after 345         100% after 345         50% after deductible           Physical Medicine - Benefit Maximum         Copay         Copay         50% after deductible           Special Medicine - Benefit Maximum         Totaliatuse and 30 Habitative and 40 Habitative and 30 Habitatitive and 30 Habitative and	Value 100% after deductible habilitative and Habil 100% after \$45 Copay Limit: 30 rehabilitative 100% after \$45 Copay Limit: 30 rehabilitative Abuse d 100% after \$45 Copay	Value         70% after deductible         itative Services         100% after \$75         Copay         ive and 30 Habilitative visits         services for the treatment of Abuse diagnosis         anced deductible         100% after \$75         Copay         ive and 30 Habilitative visits         services for the treatment of agnosis Combined with Octoor         100% after \$75         Copay         ive and 30 Habilitative visits         services for the treatment of agnosis Combined with Octoor         100% after \$75         Copay         ive and 30 Habilitative visits         services for the treatment of agnosis Combined with Octoor         100% after \$75         Copay         Limit: 20 visits/benefit	50% after deductible 50% after deductible	
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Other Services           Allergy Extracts and Injections         100% after deductible         70% after deductible         50% after deductible           Assisted Fertilization Procedures         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         100% after deductible         70% after deductible         50% after deductible           Basic Diagnostic Services (standard imaging, diagnostic Services (standard imaging, deductible         100% after 545         100% after \$75         50% after deductible           Durable Medical Equipment, Orthotics and rosthetics         100% after nehanced deductible         50% after deductible         50% after deductible           Joby & attor Basic Diagnostic Care         100% after nehanced deductible         50% after deductible         50% after deductible           Durable Medical Equipment, Orthotics and rosthetics         100% after nehanced deductible         50% after deductible         50% after deductible           Ioome Health Care         100% after nehanced deductible         50% after deductible         50% after deductible           Individual Framily         70% after nehanced deductible         50% after deductible         50% after deductible           Soft Mandatory Generic Prescr				
Allergy Extracts and Injections         100% after deductible         70% after deductible         50% after deductible           Assisted Fertilization Procedures         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         100% after deductible         70% after deductible         50% after deductible           Advanced Imaging (MRI, CAT, PET scan, etc.)         100% after deductible         70% after deductible         50% after deductible           Basic Diagnostic Services (standard imaging, diagnostic medical)         100% after \$45         100% after \$75         50% after deductible           Durable Medical Equipment, Orthotics and rosthetics         100% after 745         50% after deductible         50% after deductible           Jourge after enhanced deductible         50% after deductible         50% after deductible         50% after deductible           Hoepice         100% after         70% after deductible         50% after deductible         50% after deductible           Hoepice         100% after         70% after deductible         50% after deductible         50% after deductible           Hoepice         100% after         70% after deductible         50% after deductible         50% after				
Advanced Imaging (MRI, CAT, PET scan, etc.)         deductible         70% after deductible         50% after deductible           Advanced Imaging (MRI, CAT, PET scan, etc.)         100% after deductible         70% after deductible         50% after deductible           Basic Diagnostic Services (standard imaging, diagnostic medical)         100% after 345         100% after \$75         50% after deductible           Lab/Pathology         100% after 345         100% after 375         50% after deductible           Durable Medical Equipment, Orthotics and Prosthetics         100% after 70% after deductible         50% after deductible           Jourable Medical Equipment, Orthotics and Prosthetics         100% after 70% after deductible         50% after deductible           Jourable Medical Equipment, Orthotics and Prosthetics         100% after 70% after deductible         50% after deductible           Jourable Medical Equipment, Orthotics and Prosthetics         100% after 70% after deductible         50% after deductible           Jourable Medical Equipment, Orthotics and Prosthetics         100% after atter atter         70% after deductible         50% after deductible           Jow after Phanced deductible         50% after deductible         50% after deductible         50% after deductible           Jow after Phanced Equipment, Orthotics and         100% after atter         70% after deductible         50% after deductible           Staff An	100% after deductible	70% after deductible	50% after deductible	
Default Services related to Accidental injury         deductible         70% after deductible         50% after deductible           Diagnostic Services         100% after \$45         100% after \$45         50% after deductible           Advanced Imaging (MRI, CAT, PET scan, etc.)         100% after \$45         100% after \$75         50% after deductible           Basic Diagnostic Services (standard imaging, diagnostic medical)         100% after \$45         100% after \$75         50% after deductible           Lab/Pathology         Copay         copay         50% after deductible         50% after deductible           Jurable Medical Equipment, Orthotics and Prosthetics         100% after 70% after deductible         50% after deductible           Jone Health Care         100% after onthanced deductible         50% after deductible         50% after deductible           Iospice         100% after onthanced deductible         50% after deductible         50% after deductible           Skilled Nursing Facility Care         100% after onthanced deductible         50% after deductible         50% after deductible           Skilled Nursing Facility Care         100% after 70% after deductible         50% after deductible         50% after deductible           Freescription Drug Deductible         100% after onthanced deductible         50% after deductible         50% after deductible           Prescription Drug Program(	deductible	70% after deductible	50% after deductible	
Advanced Imaging (MRI, CAT, PET scan, etc.)     100% after deductible     70% after deductible     50% after deductible       Basic Diagnostic Services (standard imaging, diagnostic medical)     100% after \$45     100% after \$75     50% after deductible       Lab/Pathology     00% after \$45     100% after \$75     50% after deductible       Durable Medical Equipment, Orthotics and Prosthetics     100% after 70% after deductible     50% after deductible       Tore Health Care     100% after enhanced deductible     50% after deductible       Hospice     100% after enhanced deductible     50% after deductible       Nore Health Care     100% after enhanced deductible     50% after deductible       Hospice     100% after enhanced deductible     50% after deductible       Nore Respite care limit for 7 days every 6 months     100% after enhanced deductible     50% after deductible       Skilled Nursing Facility Care     100% after enhanced deductible     50% after deductible       Freecrification Requirements(7)     Prescription Drug     YES       Prescription Drug Deductible     None None     None       Prescription Drug Program(s) Soft Mandatory Generic     Sof \$10 / \$150 formulary brand Copay       Soft Mandatory Generic     Sof \$10 / \$150 formulary brand Copay       Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non- retwork pharmacy are not covered.     \$31 \\$6 / \$9 low cost generic Cop		70% after deductible	50% after deductible	
Advanced maging (WR, CA, FA, FE is starl, etc.)     deductible     70% after deductible     50% after deductible       Basic Diagnostic Services (standard imaging, diagnostic medical)     100% after \$45     100% after \$75     50% after deductible       Lab/Pathology     Copay     copay     50% after deductible     50% after deductible       Durable Medical Equipment, Orthotics and Prosthetics     100% after romance     70% after deductible     50% after deductible       Jobs     100% after romance     50% after deductible     50% after deductible       Jobs     100% after romance     50% after deductible     50% after deductible       Jobs     100% after romance     50% after deductible     50% after deductible       Jobs     100% after romance     50% after deductible     50% after deductible       Jobs     100% after romance     50% after deductible     50% after deductible       Jobs     100% after romanced deductible     50% after deductible     50% after deductible       Jobs     100% after romanced deductible     50% after deductible     50% after deductible       Jobs     100% after romanced deductible     50% after deductible     50% after deductible       Jobs     100% after romanced deductible     50% after deductible     50% after deductible       Skilled Nursing Facility Care     100% after romanced deductible     50% after deducti	100% after			
diagnostic medical)       Copay       copay       00% after deductible         Lab/Pathology       100% after \$45       100% after \$75       50% after deductible         Durable Medical Equipment, Orthotics and Prosthetics       100% after       70% after deductible       50% after deductible         Home Health Care       100% after enhanced deductible       50% after deductible       50% after deductible         Hospice       100% after enhanced deductible       50% after deductible       50% after deductible         Hospice       100% after enhanced deductible       50% after deductible       50% after deductible         Nome       100% after enhanced deductible       50% after deductible       50% after deductible         Skilled Nursing Facility Care       100% after enhanced deductible       50% after deductible         Iransplant Services       100% after       70% after deductible       50% after deductible         Prescription Drug Deductible       100% after       70% after deductible       50% after deductible         Individual Family       None       None       None         Soft Mandatory Generic       Stol formulary brand Copay       \$85 / \$170 / \$250 nor-formulary Copay       \$30 / \$6 / \$9 low cost generic Copay \$10 / \$20 / \$30 standard generic Copay         Soft Mandatory Generic       Stol formulary brand Copay       \$100 form	deductible		50% after deductible	
Lab/Pathology       Copay       copay       00% after deductible         Durable Medical Equipment, Orthotics and Prosthetics       100% after enhanced deductible       50% after deductible         Home Health Care       100% after enhanced deductible       50% after deductible         Hospice       100% after enhanced deductible       50% after deductible         Inspice       100% after enhanced deductible       50% after deductible         Infertility Counseling, Testing and Treatment(6)       100% after enhanced deductible       50% after deductible         Skilled Nursing Facility Care       100% after enhanced deductible       50% after deductible         Infertility Counseling, Testing and Treatment(6)       100% after enhanced deductible       50% after deductible         Skilled Nursing Facility Care       100% after enhanced deductible       50% after deductible         Irransplant Services       100% after deductible       50% after deductible         Prescription Drug Deductible       100% after deductible       50% after deductible         Individual       Family       Yes         Prescription Drug Program(6)       Soft Mandatory Generic       None         Soft Mandatory Generic       Soft Set of \$9 low cost generic Copay	Copay	copay	50% after deductible	
Durable Medical Equipment, Orthotics and Prosthetics         100% after deductible         70% after deductible         50% after deductible           Prosthetics         100% after enhanced deductible         50% after deductible         50% after deductible           Home Health Care         100% after enhanced deductible         50% after deductible         50% after deductible           Hospice         100% after enhanced deductible         50% after deductible         50% after deductible           Infertility Counseling, Testing and Treatment(6)         100% after enhanced deductible         50% after deductible           Skilled Nursing Facility Care         100% after enhanced deductible         50% after deductible           Skilled Nursing Facility Care         100% after rohanced deductible         50% after deductible           Freescription Requirements(7)         YES         Yes           Prescription Drug Deductible Individual Family         None None None         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.         Si / \$6 / \$9 low cost generic Copay \$10 / \$20 / \$30 standard generic Copay \$100 formulary specialty coinsurance \$350 Maximum (31-day supply-Retail) 30% non-formulary specialty coinsurance \$350 Maximum (31-day supply-Retail) 30% non-formulary specialty coinsurance \$350 Maximum (31-day supply-Retail) 30% non-formulary specialty coinsurance \$350 Maximum (31-day s			50% after deductible	
Prostnetics         Indext of the end of the	100% after		50% after deductible	
Home Health Care         Limit: 60 visits/benefit period           Hospice         100% after enhanced deductible         50% after deductible           Infertility Counseling, Testing and Treatment(6)         100% after enhanced deductible         50% after deductible           Skilled Nursing Facility Care         100% after enhanced deductible         50% after deductible           Skilled Nursing Facility Care         100% after enhanced deductible         50% after deductible           Transplant Services         100% after deductible         50% after deductible           Prescription Requirements(7)         YES           Prescription Drug Deductible         None           Individual Family         None           Prescription Drug Program(8)         Soft Mandatory Generic           Soft Mandatory Generic         Opay           Defined by the National Pharmacy Network - Not         %3 / \$6 / \$9 low cost generic Copay \$300 Maximum (31-day supply-Retail)           30% non-formulary specialty coinsurance \$350 Maximum (31-day supply-Retail)           30% non-formulary specialty coinsurance \$300 Maximum (31-day supply-Retail)           \$30% non-formulary specialty coinsurance \$300 Maximum (31-day supply-Retail)           \$30% non-formulary specialty coinsurance \$300 Maximum (31-day supply-Retail)           \$30% non-formulary specialty coinsurance \$300 Maximum (31-day supply-Retail)				
Hospice         100% after enhanced deductible         50% after deductible           Respite care limit of 7 days every 6 months         Respite care limit of 7 days every 6 months           Infertility Counseling, Testing and Treatment(6)         100% after enhanced deductible         50% after deductible           Skilled Nursing Facility Care         100% after enhanced deductible         50% after deductible           Skilled Nursing Facility Care         100% after enhanced deductible         50% after deductible           Transplant Services         100% after deductible         50% after deductible           Prescription Requirements(7)         YES           Prescription Drug Deductible         None           Individual         None           Family         Retail Drugs (31/60/90-day Supply)           \$3 / \$6 / \$9 low cost generic Copay \$10 /\$200 \$30 standard generic Copay           Saf / \$6 / \$9 low cost generic Copay \$10 /\$200 \$30 standard generic Copay           Prescription Drug Program(8)         \$3 / \$6 / \$9 low cost generic Consumance \$300 Maximum (31-day supply-Retail)           30% non-formulary specialty coinsurance \$300 Maximum (31-day supply-Retail)           Physician Network. Prescriptions filled at a non-           network pharmacy are not covered.           Your plan uses the HCR Comprehensive Formulary           Your plan uses the HCR Comprehensive Formulary	100% after enn			
Hospice       Respite care limit of 7 days every 6 months         Infertility Counseling, Testing and Treatment(6)       100% after deductible       70% after deductible       50% after deductible         Skilled Nursing Facility Care       100% after enhanced deductible       50% after deductible         Infertility Counseling, Testing and Treatment(6)       100% after deductible       50% after deductible         Skilled Nursing Facility Care       100% after enhanced deductible       50% after deductible         Infertility Counseling, Testing and Treatment(6)       100% after enhanced deductible       50% after deductible         Skilled Nursing Facility Care       100% after deductible       50% after deductible         Infertility Counseling, Testing and Treatment(6)       100% after enhanced deductible       50% after deductible         Frescription Requirements(7)       YES         Prescription Drug Deductible       None       None         Individual Family       None       None         Prescription Drug Program(6)       \$3 / \$6 / \$9 low cost generic Copay \$10 / \$150 formulary brand Copay         Soft Mandatory Generic       Defined by the National Pharmacy Network - Not         Physician Network. Prescriptions filled at a non-       formulary specialty coinsurance \$500 Maximum (31-day supply-Retar)         Soft Mandatory Generic       Soft ormulary specialty coinsurance \$500 Maximum (	100% after enh			
Image: Stable String and Treatment(6)       100% after deductible       50% after deductible         Skilled Nursing Facility Care       100% after enhanced deductible       50% after deductible         Skilled Nursing Facility Care       100% after enhanced deductible       50% after deductible         Individual Family       100% after deductible       50% after deductible         Prescription Drug Deductible       100% after deductible       50% after deductible         Individual Family       Yes       Yes         Prescription Drug Program(8)       None       None         Soft Mandatory Generic       20% formulary specialty coinsurance \$30 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$30 Maximum (31-day supply)       \$3 low cost generic Copay \$10 degay supply)         Soft Mandatory Generic       50% non-formulary specialty coinsurance \$50 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$30 Maximum (31-day supply)       \$3 low cost generic Copay \$10 degay supply)         \$3 low cost generic Copay \$10 degay supply)       \$3 low cost generic Copay \$10 degay supply)         \$3 low cost generic Copay \$10 degay supply)       \$3 low cost generic Copay \$10 degay supply)         \$3 low cost generic Copay \$10 degay supply)       \$3 low cost generic Copay \$10 degay supply)         \$3 low cost generic Copay \$10 degay supply) <t< td=""><td>Re</td><td></td><td></td></t<>	Re			
Skilled Nursing Facility Care       Limit: 120 days/benefit period         Transplant Services       100% after deductible       70% after deductible       50% after deductible         Precertification Requirements(7)       YES         Prescription Drug Deductible Individual Family       None None         Prescription Drug Program(8)       None         Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non- network pharmacy are not covered.       \$3 / \$6 / \$9 low cost generic Copay \$10 /\$20/ \$30 standard generic Copay \$85 / \$170 / \$255 non-formulary brand Copay \$85 / \$170 / \$255 non-formulary Copay         Your plan uses the HCR Comprehensive Formulary with an Incentive Benefit Design.       Waintenance Drugs through Mail Order (90-day Supply) \$3 low cost generic Copay \$10 standard generic Copay \$170 non-formulary brand Copay \$170 non-formulary brand Copay         Your plan uses the HCR Comprehensive Formulary with an Incentive Benefit Design.       Yeit Plan uses the HCR Comprehensive Formulary \$170 non-formulary brand Copay	100% after deductible	70% after deductible	50% after deductible	
Transplant Services       100% after deductible       70% after deductible       50% after deductible         Prescription Requirements(7)       YES         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.       Soft Mandatory generic Copay \$10 (\$20) (\$30) standard generic Copay \$50 / \$100 / \$150 formulary brand Copay 20% formulary specialty coinsurance \$350 Maximum (31-day supply-Retail) 30% non-formulary specialty coinsurance \$500 Maximum (31-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)	100% after enh			
Indisplant Services       deductible       70% after deductible       50% after deductible         Precertification Requirements(7)       YES         Prescription Drug Deductible Individual Family       Prescription Drugs         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.       \$3 / \$6 / \$9 low cost generic Copay \$10 / \$20/ \$30 standard generic Copay \$3 / \$6 / \$9 low cost generic Copay \$350 Maximum (31-day supply-Retail) 30% non-formulary specialty coinsurance \$350 Maximum (31-day supply-Retail) 30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail) 30% non-formulary specialty coinsurance \$10 standard generic Copay \$100 formulary brand Copay \$100 formulary brand Copay \$100 non-formulary brand Copay \$100 non-formulary brand Copay \$100 formulary brand Copay	100% after		•	
Prescription Drug Deductible       None         Individual       None         Family       Retail Drugs (31/60/90-day Supply)         Prescription Drug Program(8)       \$3 / \$6 / \$9 low cost generic Copay \$10 /\$20/ \$30 standard generic Copay         Soft Mandatory Generic       20% formulary specialty coinsurance \$350 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         30% non-formulary specialty coinsurance \$10 standard generic Copay         \$3 low cost generic Copay \$10 standard generic Copay         \$3 low cost generic Copay \$10 standard generic Copay         \$100 formulary brand Copay         \$20% formulary specialty coinsurance \$10 standard generic Copay         \$100 formulary brand C		70% after deductible	50% after deductible	
Prescription Drug Deductible Individual Family       None None         Prescription Drug Program(8)       Retail Drugs (31/60/90-day Supply)         Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non- network pharmacy are not covered.       Soft Maintenance Drugs through Mail Order (90-day Supply)         Your plan uses the HCR Comprehensive Formulary with an Incentive Benefit Design.       Maintenance Drugs through Mail Order (90-day Supply)         Soft formulary specialty coinsurance \$700 Maximum (Mail Order)				
Individual Family None None None <b>Retail Drugs (31/60/90-day Supply)</b> (\$3 / \$6 / \$9 low cost generic Copay \$10 / \$20' \$30 standard generic Copay \$50 / \$100 / \$150 formulary brand 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) \$3 low cost generic Copay \$10 standard generic Copay \$100 formulary brand Copay	Prescription Drugs	3		
Family       None         Retail Drugs (31/60/90-day Supply)         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.    None Retail Drugs (31/60/90-day Supply)          \$3 / \$6 / \$9 low cost generic Copay \$10 /\$20' \$30 standard generic 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)         \$3 low cost generic Copay \$10 standard generic Copay         \$100 formulary brand Copay <td></td> <td>Nana</td> <td></td>		Nana		
Retail Drugs (31/60/90-day Supply)         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         Your plan uses the HCR Comprehensive Formulary         20% formulary specialty coinsurance \$10 dating         \$100 dating         \$20% formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         \$30% non-formulary specialty coinsurance \$500 Maximum (31-day supply)         \$30% non-formulary specialty coinsurance \$10 standard generic Copay         \$100 formulary brand Copay         \$100 formula				
Prescription Drug Program(8)       \$85 / \$170 / \$255 non-formulary Copay         Soft Mandatory Generic       20% formulary specialty coinsurance \$350 Maximum (31-day supply-Retail)         Defined by the National Pharmacy Network - Not       30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)       30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)       30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)       30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)       30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$10 Maximum (Mail Order)       \$3100 non-formulary brand Copay         \$100 non-formulary brand Copay       \$100 non-formulary brand Copay         20% formulary specialty coinsurance \$700 Maximum (Mail Order)       20% formulary specialty coinsurance \$700 Maximum (Mail Order)		Retail Drugs (31/60/90-da	av Supply)	
Prescription Drug Program(8)       \$85 / \$170 / \$255 non-formulary Copay         Soft Mandatory Generic       20% formulary specialty coinsurance \$350 Maximum (31-day supply-Retail)         Defined by the National Pharmacy Network - Not       30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)       30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)       30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)       30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)       30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$10 Maximum (Mail Order)       \$3100 non-formulary brand Copay         \$100 non-formulary brand Copay       \$100 non-formulary brand Copay         20% formulary specialty coinsurance \$700 Maximum (Mail Order)       20% formulary specialty coinsurance \$700 Maximum (Mail Order)	\$3 / \$6 / \$9 low cos	t generic Copay \$10 /\$2	0/ \$30 standard generic Copay	
Prescription Drug Program(8)       \$85 / \$170 / \$255 non-formulary Copay         Soft Mandatory Generic       20% formulary specialty coinsurance \$350 Maximum (31-day supply-Retail)         Defined by the National Pharmacy Network - Not       30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)       30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)       30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)       30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)       30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)         20% formulary specialty coinsurance \$10 Maximum (Mail Order)       \$3100 non-formulary brand Copay         \$100 non-formulary brand Copay       \$100 non-formulary brand Copay         20% formulary specialty coinsurance \$700 Maximum (Mail Order)       20% formulary specialty coinsurance \$700 Maximum (Mail Order)	\$	50 / \$100 / \$150 formulary	brand Copay	
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. 30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Reta 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)	20% formulary and	abo / \$1/U / \$255 non-form	ulary Copay Javimum (31-day supply Poteil)	
Physician Network. Prescriptions filled at a non- network pharmacy are not covered. Your plan uses the HCR Comprehensive Formulary with an Incentive Benefit Design. 20% formulary specialty coinsurance \$700 Maximum (Mail Order)	20% iorniulary specialty coinsurance \$350 Maximum (31-day supply-Retail) 30% non-formulary specialty coinsurance \$500 Maximum (31-day supply-Retail)			
network pharmacy are not covered. Your plan uses the HCR Comprehensive Formulary with an Incentive Benefit Design. 20% formulary specialty coinsurance \$700 Maximum (Mail Order)	so to hori to mulary op		maximum (or day supply rield	
<i>Your plan uses the HCR Comprehensive Formulary</i> <i>with an Incentive Benefit Design.</i> 20% formulary specialty coinsurance \$700 Maximum (Mail Order)	Maintena	nce Drugs through Mail O	rder (90-day Supply)	
with an Incentive Benefit Design. \$170 non-formulary brand Copay 20% formulary specialty coinsurance \$700 Maximum (Mail Order)	\$3 low cost generic Copay \$10 standard generic Copay			
20% formulary specialty coinsurance \$700 Maximum (Mail Order) 30% non-formulary specialty coinsurance \$1000 Maximum (Mail Order)		\$100 formulary brand	Copay	
30% non-formulary specialty coinsurance- \$1000 Maximum (Mail Order)	20% formulary specialty coinsurance \$700 Maximum (Mail Order)			
	30% non-formulary specialty coinsurance- \$1000 Maximum (Mail Order)			
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(2) Services must be performed by a Highmark approved telemedicine provider.
 (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.

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program. 04/27/2024 Flex PPO PA Mountains Healthcare Region \$500/\$1500 a Community Blue Plan H-TIERED-PENNHIGH-PA

Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.

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. Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered

- (6)
- (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 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.

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.

## **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 need these services, contact the CIVII 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).

تتبيه: إذا كنت تتحدث اللغة العربية، فهنك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 211).

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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