Summary of Premier Balance PPO \$1500 IP A a Community On the chart below, you'll see what your plop page for acceptance.

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.

Deductible (per benefit period) (All Irn-retwork services are credited to both the standard and the enhanced deductibles.) Individual \$3,000 \$4,500 \$27,000 \$2	remefit Period(1) General Provisions Contract Year Contract Yea	Benefit	Network		Out-of-Network
Benefit Periodic) Deductible (per benefit period) (All in-network services are credited to both the standard and the enhanced deductibles). Family Plan Pays – payment based on the plan allowance Out-of-Pocket Limit (includes deductible) Includidual Family Office/Clinic/Urgent Carre Visits Office/Clinic/Urgent Carre Visits Office/Clinic/Urgent Carre Visits Office/Clinic/Urgent Carre Visits Oppay Oppay Oppay Frimary Care Provider Office Visits & Virtual Visits Office & Virtual Visits Oppay Oppay Virtual Visit Originating Site Fee double and 570 Oppay Oppa	entert Period: Evolutible (per benefit period) (All in-network evolutions are credited to both the standard and the Individual Standard Stand		Enhanced Value	Standard Value	
Deductible (per benefit period) (All in-network services are credited to both the standard and the inflavoid deductibles.) S1,500	educible (per benefit period) (All in-network prices are receited to both the standard and the thanced deductibles). \$1,500 \$2,0	Constit Portod(4)	General Provisions		
services are credited to both the standard and the nihanaced deductibles \$1,500	ervices are credited to both the standard and the hanced deductibles.) In an experience of the part of the hanced deductible of the hanced of the			T Contract real	
Individual sample - payment based on the plan allowance of the pla	Individual Stanto \$4,500 \$13,500 \$27,000 Ian Pays – payment based on the plan allowance deductable of the plan pays of the p	services are credited to both the standard and the			
Plan Pays – payment based on the plan allowance Durt-OF-Pocket Limit (Includes deductible deductible Durt-OF-Pocket Limit (Includes deductible, Once met, plan pays to provide the plan deductible deductible structure of the rest of the benefit period.) S7, 150	Ian Pays – payment based on the plan allowance 100% after 100% a	enhanced deductibles.)	_		
Plan Pays – payment based on the plan allowance 100% after deductible 70% after deductible 50% after deduct	Ian Pays – payment based on the plan allowance 100% after 100% a		\$1,500	\$4,500	\$13,500
Department passed in the pair allowance deductible 0.0% after deductible 0	teal rays – payments of the plan allowance deductible visco-Procket Limit (includes deductible visco-Procket Limit (includes deductible pays) sinsurance and copayments. Once met, plan pays of the pays of the plan pays of the pays of the plan pays of the pays of the pays of the plan pays of the plan pays of the plan pays of the pays of the plan pays of the plan pays of the plan pays of the pays of the plan pays of the plan pays of the plan pays of the pays of t	Family		\$9,000	\$27,000
Du-Jo-Pocket Limit (includes deductible consurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period.) Individual St.4, 300 \$21,450 \$42,900 \$42,	ub-of-Pocket Limit (Includes deductible, insurance and copanyments, Once met, plan pays) 57,150 \$21,450 \$42,900	Plan Pays – payment based on the plan allowance		70% after deductible	50% after deductible
coinsurance and copayments. Once met, plan pays (10% coinsurance for the rest of the benefit period.) Individual (10% coinsurance for the rest of the benefit period.) (10% coinsurance for the rest of the benefit period.) (10% coinsurance for the rest of the benefit period.) (10% after 24 15 10% after 34 100%	consurance and copayments. Once met, plan pays office/Clinic/Urgent Care Visits Visit State Sta	Out-of-Pocket Limit (Includes deductible	deductible	1	
100% coinsurance for the rest of the benefit period.) Family	S7 150 \$21,450 \$42,900 \$42	coinsurance and copayments. Once met. plan pays			
Retail Clinic Visits & Virtual Visits 100% after \$45 deductible and \$70 Copay	etail Clinic Visits & Virtual Visits 100% after \$45 100% after 450 Copay 100% after \$45 100% after \$45 Copay 100% after \$50 Copay 100	100% coinsurance for the rest of the benefit period.)			
Retail Clinic Visits & Virtual Visits 100% after \$45 deductible and \$70 Copay	etail Clinic Visits & Virtual Visits 100% after \$45 100% after 450 Copay 100% after \$45 100% after \$45 Copay 100% after \$50 Copay 100		\$7	,150	\$21,450
Retail Clinic Visits & Virtual Visits 100% after \$45 Copay Copay 50% after deductible and \$70 Copay 100% after copay 100% after deductible and \$70 Copay 100% after deductible 20% after deductible 20% after copay 100% after cop	etail Clinic Visits & Virtual Visits 100%, after \$45	Family			\$42,900
Retail Clinic Visits & Virtual Visits Primary Care Provider Office Visits & Virtual Visits Primary Care Provider Office Visits & Virtual Visits Specialist Office & Virtual Visits 100% after \$45	rimary Care Provider Office Visits & Virtual Visits rimary Care Provider Office Visits & Virtual Visits Copay pecialist Office & Virtual Visits 100% after \$45 Copay deductible and \$70 Copay deductible and \$70 Copay deductible and \$70 Copay deductible and \$70 Copay for after \$45 Copay virtual Visit Originating Site Fee 100% after \$70 Copay Virtual Visit Originating Site Fee deductible rgent Care Center Visits 100% after \$85 Copay 100% after \$85 Copay Took after \$80 Copay Took after \$85 Copay Not Covered Preventive Care(s) Took after \$15 Copay Not Covered Preventive Care(s) Adult immunizations 100% 50% after deductible Took after \$15 Copay Not Covered Took after \$15 Copay Took after \$15 Copa			VISITS	
Primary Care Provider Office Visits & Virtual Visits 100% after \$45	rimary Care Provider Office Visits & Virtual Visits 100% after \$45 Copay 100% after \$70 Copay 100% after \$90 Copay 100% after \$10 Copa	Retail Clinic Visits & Virtual Visits			50% after deductible
Primary Care Provider Office Visits & Virtual Visits Specialist Office & Virtual Visits 100% after \$45 Copay 100% after \$70 Copay 100% after \$90 Copay Virtual Visit Originating Site Fee 100% after \$70 Copay 100% after \$90 Copay Virtual Visit Originating Site Fee 100% after \$70 Copay 100% after \$90 Copay 100% after \$10 Copay 100% after deductible 100% after \$10 Copay 100% after \$10 Copay 100% after \$10 Copay 100% after \$10 Copay 100% after deductible \$10 Copay 100% after de	rimary Care Provider Office Visits & Virtual Visits 100% after \$45	Totali Cililo W Villaui Violo	Copay		oo /o artor doddonoro
Specialist Office & Virtual Visits Specialist Office & Virtual Visits Ocopay Virtual Visit Originating Site Fee Ocopay	pocialist Office & Virtual Visits Copay Pocialist Office & Virtual Visits Copay Virtual Visit Originating Site Fee Copay Virtual Visit Originating Site Fee Copay Virtual Visit Originating Site Fee Copay Not Covered Preventive Care(a) Adult Adult Immunizations Colorectal cancer screening Colore		100% after \$45	100% after	
Specialist Office & Virtual Visits Virtual Visit Originating Site Fee 100% after \$70 100% after \$90 Copay	pecialist Office & Virtual Visits Copay	²rimary Care Provider Office Visits & Virtual Visits │			50% after deductible
Virtual Visit Originating Site Fee 100% after 100%	Virtual Visit Originating Site Fee			Copay	
Virtual Visit Originating Site Fee	Virtual Visit Originating Site Fee	Specialist Office & Virtual Visits			50% after deductible
Urgent Care Center Visits Urgent Care Center Visits 100% after \$85 Copay 100% after \$85 Copay 100% after \$85 Copay Not Covered Preventive Care(s) Routine Adult Adult immunizations 100% Adult immunizations 100% 50% after deductible 50% after deductible 100% 50% after deductible 50% after deductible 100% 100% 100% 100%	regent Care Center Visits elemedicine Services(2) 100% after \$85 Copay 100% after \$15 Copay Not Covered Preventive Care(3) Adult immunizations 100% 100% 50% after deductible Diagnostic services and procedures Mammograms (annual routine) Magior Services (annual routine) Major Services (annual gam restorations (metal fillings), resin based composite fillings (white Magior Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(s) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) 100% after deductible Sow, after deductible Sow, after deductible Sow, after deductible Sow, after deductible Mammograms (annual routine) Not Covered Not Covered Not Covered Not Covered Not Covered Sow, after deductible Not Covered Not Covered Not Covered Not Covered Not Covered Sow, after deductible Not Covered Sow, after deductible Not Covered No	·	100% after	- ' '	
Drigent Care Center Visits	rgent Care Center Visits elemedicine Services(2) 100% after \$15 Copay 100% after \$15 Copay Not Covered Preventive Care(3) Adult immunizations Adult immunizations Colorectal cancer screening 100% 50% after deductible Diagnostic services and procedures 100% 50% after deductible Diagnostic services and procedures 100% 50% after deductible Marmograms (annual routine) 100% 100% 50% after deductible Marmograms (annual routine) 100% 50% after deductible 100% 50% after deductible 50% after deductible 100% 50% after deductible 100% 50% after deductible 50% after deductible 100% 50% after deductible 100% 50% after deductible 50% 60% 60% 60% 60% 60% 60% 60% 60% 60% 6	Virtual Visit Originating Site Fee		70% after deductible	50% after deductible
relemedicine Services(2) 100% after \$15 Copay Solutine Adult Adult immunizations Adult immunizations 100% Adult immunizations 100% Solve after deductible 100gnostic services and procedures 100% 100% 100% Solve after deductible 100% Solve after deductible 100% Solve after deductible 100% Mammograms (annual routine) 100% 100% 100% Solve after deductible 100% Solve after deductible 100% Mammograms (medically necessary) 100% 100% Solve after deductible 100% Solve after deductib	Copay Copay Copay Soft and reductible Copay Copay Soft and reductible Copay	Urgant Cara Cantar Vialta	100% after \$85	100% after \$100	E00/ ofter deductible
Routine Adult Adult immunizations Colorectal cancer screening 100% 50% after deductible 100% 50%	Outline Adult Adult immunizations Colorectal cancer screening Diagnostic services and procedures Mammograms (annual routine) Mamograms (annual routine) Mamog	-		Copay	
Adult immunizations 100% 50% after deductible Colorectal cancer screening 100% 50% after deductible Diagnostic services and procedures 100% 50% after deductible Mammograms (annual routine) 100% 50% after deductible Mammograms (medically necessary) 100% 100% 50% after deductible Mammograms (medically necessary) 100% 100% 50% after deductible Physical exams (medically necessary) 100% 50% after deductible Routine gynecological exams, including a Pap Test 100% 50% after deductible Routine adult vision Screening 100% Not Covered Routine adult vision Screening 100% Not Covered Routine adult vision Screening 100% 50% after deductible Pediatric immunizations 100% 50% after deductible Pediatric immunizations 100% 50% after deductible Pediatric immunizations 100% 50% after deductible Pediatric fimmunizations 100% 50% after deductible Some Physical exams 100% 50% after deductible Pediatric fimmunizations 100% 50% after deductible Some Physical exams 100% 50% after deductible Physical exams	outine Adult Adult munizations Colorectal cancer screening Adult immunizations Colorectal cancer screening 100% 50% after deductible 100% 50% after deductible 100% 50% after deductible 50% after deductible 100% after deducti	Telemedicine Services(2)			Not Covered
Adult immunizations 100% 50% after deductible Colorectal cancer screening 100% 50% after deductible Diagnostic services and procedures 100% 50% after deductible Diagnostic services and procedures 100% 100% 50% after deductible Mammograms (annual routine) 100% 100% 50% after deductible Mammograms (medically necessary) 100% 100% 50% after deductible Physical exams 100% 50% after deductible Routine gynecological exams, including a Pap Test 100% 50% after deductible Routine adult vision Screening 100% 50% after deductible Diagnostic services and procedures 100% 50% after deductible Pediatric immunizations 100% 50% after deductible Pediatric immunizations 100% 50% after deductible Pediatric Vision(4) 50% after deductible Pediatric Vision(4) 50% after deductible Pediatric Immunizations 100% 50% after deductible Pediatric Pediat	Adult immunizations Colorectal cancer screening 100% Solva after deductible Diagnostic services and procedures 100% Solva after deductible Diagnostic services and procedures 100% Solva after deductible Mammograms (annual routine) 100% Solva after deductible Mammograms (medically necessary) 100% Solva after deductible Physical exams Routine gynecological exams, including a Pap Test Routine gynecological exams Routine gynecological exams and including gynecological gynecological gynecological exams and including gynecological gynecological gynecological	Sanding Adada	Preventive Care(3)		
Colorectal cancer screening Diagnostic services and procedures 100% 100% 100% 50% after deductible Mammograms (annual routine) 100% 100% 100% 50% after deductible Mammograms (medically necessary) 100% 100% 50% after deductible Mammograms (medically necessary) 100% 50% after deductible Noutine gynecological exams, including a Pap Test 100% 50% after deductible Routine gynecological exams, including a Pap Test Routine adult vision Screening 100% Not Covered Routine Pediatric Diagnostic services and procedures 100% 50% after deductible Pediatric immunizations 100% 50% after deductible 100% 50% after deductible 50% after deductible 100% 100% 100% 100% 100% 100% 100% 100	Colorectal cancer screening Diagnostic services and procedures Diagnostic services and procedures Mammograms (annual routine) Mammograms (annual routine) Mammograms (medically necessary) 100% 100% 100% 50% after deductible Mammograms (medically necessary) 100% 100% 50% after deductible Physical exams Routine gynecological exams, including a Pap Test Routine gynecological exams, including a Pap Test Routine gynecological exams, including a Pap Test Routine adult vision Screening 100% Not Covered Outine Pediatric Diagnostic services and procedures Pediatric immunizations 100% 50% after deductible Pediatric immunizations 100% 50% after deductible Pediatric rimmunizations 100% 50% after deductible Pediatric Vision(4) - Davis Vision National Network Exam (including dilation, as professionally indicated) 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) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Basic Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontic(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) \$100% after deductible 50% after deductible		4.0	200/	FOO/ -ftltible
Diagnostic services and procedures 100% 50% after deductible Mammograms (annual routine) 100% 100% 50% after deductible Mammograms (medically necessary) 100% 100% 50% after deductible Mammograms (medically necessary) 100% 50% after deductible Physical exams 100% 50% after deductible Routine gynecological exams, including a Pap Test 100% 50% after deductible Routine gynecological exams, including a Pap Test 100% 50% after deductible Routine gynecological exams, including a Pap Test 100% 50% after deductible Routine Pediatric Diagnostic services and procedures 100% 50% after deductible Pediatric immunizations 100% 50% after deductible Pediatric Vision(4) 50% after deductible Pediatric Vision(4) 50% after deductible Pediatric Vision National Network Exam (including dilation, as professionally indicated) 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) Not Covered Sealants) Not Covered Sealants Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Not Covered Not	Diagnostic services and procedures 100% 50% after deductible Mammograms (annual routine) 100% 100% 50% after deductible Mammograms (medically necessary) 100% 100% 50% after deductible Mammograms (medically necessary) 100% 100% 50% after deductible Physical exams including a Pap Test 100% 50% after deductible Routine gynecological exams, including a Pap Test 100% Not Covered Outline Adult vision Screening 100% Not Covered Outline Adult vision Screening 100% 50% after deductible Pediatric immunizations 100% 50% after deductible Pediatric Vision(a) Davis Vision National Network Exam (including dilation, as professionally indicated) 100% Not Covered Not Covered Standard eyeglass lenses (per pair) 100% Not Covered Pediatric Dental(a) Not Covered Pediatric Dental(b) Not Covered Not Covered Pediatric Dental(b) Not Covered Standard eyeglass lenses (per pair) 100% Not Covered Not Covered Pediatric Dental(b) Not Covered Pediatric Dental(c) Not Covered Not Covered Not Covered Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Not Covered Services (exam glam restorations (metal fillings)) Not Covered Not Covered Not Covered Not Covered Najor Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) 50% Not Covered Not Covered Not Covered Najor Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) 70% after deductible 50% after deductible Sovalter deductible Not Covered Not Covered Not Covered Najor Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) 70% after deductible 50% after deductible Not Router deduct				
Mammograms (annual routine) 100% 100% 50% after deductible Physical exams (medically necessary) 100% 100% 50% after deductible Physical exams (medically necessary) 100% 50% after deductible Physical exams including a Pap Test 100% 50% after deductible Routine gynecological exams, including a Pap Test 100% Not Covered Routine Pediatric Diagnostic services and procedures 100% 50% after deductible Pediatric immunizations 100% 50% after deductible Pediatric immunizations 100% 50% after deductible Pediatric immunizations 100% 50% after deductible Pediatric frame selection 100% 50% after deductible Pediatric frame selection 100% Not Covered Pediatric frame selection 100% Not Covered Pediatric frame selection 100% Not Covered Pediatric Dental(4) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(s) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Mammograms (annual routine) Mammograms (medically necessary) 100% 100% 100% 50% after deductible Physical exams 100% Routine gynecological exams, including a Pap Test Routine gynecological exams, including a Pap Test Routine godult vision Screening 100% Not Covered 100% Not Covered 100% 100% Not Covered 100% 100% Not Covered 100% 100% 100% 100% Not Covered 100% 10	Diagnostic convices and procedures			
Mammograms (medically necessary) 100% 50% after deductible Physical exams 100% 50% after deductible Routine gynecological exams, including a Pap Test 100% 50% after deductible Routine gynecological exams, including a Pap Test 100% Not Covered Routine adult vision Screening 100% Not Covered Routine adult vision Screening 100% Not Covered Routine adult vision Screening 100% Sow after deductible Pediatric Immunizations 100% 50% after deductible Pediatric Immunizations 100% 50% after deductible Pediatric Vision(4) 50% after deductible Pediatric Vision(4) 100% 50% after deductible Pediatric Vision(4) 100% Not Covered Scandard eyeglass lenses (per pair) 100% Not Covered Standard eyeglass lenses (per pair) 100% Not Covered Standard eyeglass lenses (per pair) 100% Not Covered Pediatric Dental(4) 100% Not Covered Standard eyeglass lenses (per pair) 100% Not Covered Not Covered Per Pair deductible 100% N	Mammograms (medically necessary) Physical exams Routine gynecological exams, including a Pap Test Routine gynecological exams, including a Pap Test Routine gynecological exams, including a Pap Test Routine adult vision Screening Outline Padiatric Diagnostic services and procedures Pediatric immunizations 100% 50% after deductible Fediatric immunizations 100% 50% after deductible Fediatric immunizations 100% 50% after deductible Fediatric Vision(4) Fow after deductible Fediatric Vision(5) Fow after deductible Fediatric Vision(6) Fow after deductible Fediatric Vision(7) Fediatric frame selection 100% Not Covered Fediatric frame selection 100% Not Covered Standard eyeglass lenses (per pair) Fediatric Dental(6) United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Major Services (fedically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) **Tow, ofter deductible for the deductible admiration for the control of the deductible for t	Mammograms (annual routine)			
Physical exams Routine gynecological exams, including a Pap Test Routine gynecological exams, including a Pap Test Routine gynecological exams, including a Pap Test Routine Pediatric Diagnostic services and procedures Diagnostic services and procedures Pediatric immunizations 100% Sow after deductible Foldatric immunizations 100% Sow after deductible Foldatric Vision(4) Pediatric Vision(5) Davis Vision National Network Exam (including dilation, as professionally indicated) Pediatric frame selection Pediatric frame selection Standard eyeglass lenses (per pair) Pediatric Dental(4) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (Including maternity)	Physical exams Routine gynecological exams, including a Pap Test Routine adult vision Screening 100% Routine adult vision Screening 100% Not Covered Not Covered 100% Sow after deductible Sow after deductible Sow after deductible Sow after deductible Pediatric immunizations Policy indicated Pediatric Vision(4) Physical exams Pediatric Vision(6) Davis Vision National Network Exam (including dilation, as professionally indicated) Pediatric frame selection Standard eyeglass lenses (per pair) 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) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) S1000 copay, per admission then 100% after deductible S0% after deductible	Mammograms (medically necessary)			
Routine gynecological exams, including a Pap Test Routine adult vision Screening Routine Padiatric Diagnostic services and procedures Pediatric immunizations Pediatric Vision(a) Pediatric Vision(b) Pediatric Vision(a) Position National Network Exam (including dilation, as professionally indicated) Pediatric frame selection Standard eyeglass lenses (per pair) Pediatric Dental(a) United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(s) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Routine gynecological exams, including a Pap Test 100% 50% Routine adult vision Screening 100% 100% Not Covered 200tine Pediatric 50% after deductible 70% 50% after deductible 70% after deductible 7				
Routine Adult vision Screening Routine Pediatric Diagnostic services and procedures Pediatric Immunizations Physical exams Physical exams 100% S0% after deductible Pediatric Vision(4) Davis Vision National Network Exam (including dilation, as professionally indicated) Pediatric frame selection Standard eyeglass lenses (per pair) United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Routine adult vision Screening outline Pediatric Diagnostic services and procedures 100% 50% after deductible Pediatric immunizations 100% 50% after deductible Pediatric immunizations 100% 50% after deductible Pediatric Vision(4) - Physical exams 100% 50% after deductible Pediatric Vision(4) - Davis Vision National Network Exam (including dilation, as professionally indicated) 100% Not Covered Standard eyeglass lenses (per pair) 100% Not Covered Pediatric Pental(4) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) 100% Not Covered Standard Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings), resin based composite fillings (white fillings) 100% Not Covered Not Covered Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) 100% Not Covered Not Covered Not Covered Services (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) 50% after deductible 50% after deductible 100% after 100% af	Routine gynecological exams, including a Pap Test			
Diagnostic services and procedures Pediatric immunizations Physical exams Polyais Vision National Network Exam (including dilation, as professionally indicated) Pediatric Frame selection Pediatric Dental(4) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings), resin based composite fillings (white fillings) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Diagnostic services and procedures Pediatric immunizations 100% Pediatric immunizations 100% 50% after deductible 100% 50% after deductible 50% after deductible 50% after deductible 100% Soft after deductible 50% after deductible 100% Soft after deductible 50% after deductible	Routine adult vision Screening	10	00%	
Pediatric immunizations Physical exams 100% 50% after deductible Pediatric Vision(4) - Davis Vision National Network Exam (including dilation, as professionally indicated) Pediatric frame selection 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) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Pediatric immunizations Physical exams 100% S0% after deductible Pediatric Vision(4) - Davis Vision National Network Exam (including dilation, as professionally indicated) Pediatric frame selection Pediatric Dental(4) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) Spital Inpatient 100% S0% S0% S0% S0% S0% S0% S0% S0% S0%				
Physical exams Pediatric Vision(a) - Davis Vision National Network Exam (including dilation, as professionally indicated) Pediatric frame selection Standard eyeglass lenses (per pair) Pediatric Dental(a) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(s) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Physical exams Pediatric Vision(4) - Davis Vision National Network Exam (including dilation, as professionally indicated) Pediatric frame selection Standard eyeglass lenses (per pair) Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) spital Inpatient 100% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible				
Pediatric Vision(4) - Davis Vision National Network Exam (including dilation, as professionally indicated) Pediatric frame selection Standard eyeglass lenses (per pair) Pediatric Dental(4) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (Including maternity)	Pediatric Vision(4) - Davis Vision National Network Exam (including dilation, as professionally indicated) Pediatric frame selection Standard eyeglass lenses (per pair) Pediatric Dental(4) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) Spital Inpatient Over after deductible Proventive Very Very Control of Spital deductible 100% after deductible Spital Proventions Not Covered 70% after deductible				
Davis Vision National Network Exam (including dilation, as professionally indicated) Pediatric frame selection Standard eyeglass lenses (per pair) Pediatric Dental(4) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Davis Vision National Network Exam (including dilation, as professionally indicated) Pediatric frame selection Standard eyeglass lenses (per pair) Pediatric Dental(a) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) \$100% after deductible 50% after deductible		10	00%	50% after deductible
Exam (including dilation, as professionally indicated) Pediatric frame selection Standard eyeglass lenses (per pair) Pediatric Dental(4) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Exam (including dilation, as professionally indicated) Pediatric frame selection Standard eyeglass lenses (per pair) Pediatric Dental(4) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) Saloto copay, per admission then 100% after deductible 100% after deductible	• • • • • • • • • • • • • • • • • • • •			
indicated) Pediatric frame selection Standard eyeglass lenses (per pair) Pediatric Dental(4) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	indicated) Pediatric frame selection Standard eyeglass lenses (per pair) Pediatric Dental(4) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) \$100% after 70% after deductible 100% after deductible \$100% after 70% after deductible \$100% after deductible \$100% after 70% after deductible \$100% after deductible \$100% after 70% after deductible \$100% after 70	Davis Vision National Network			
Pediatric frame selection 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) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Pediatric frame selection Standard eyeglass lenses (per pair) 100% Not Covered		10	00%	Not Covered
Standard eyeglass lenses (per pair) Pediatric Dental(4) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Standard eyeglass lenses (per pair) Pediatric Dental(4) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) \$1000 copay, per 70% after deductible 100% after 70% after deductible 50% afte		10	000/	Not Covered
Pediatric Dental(4) - United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) \$1000 copay, per admission then 100% after deductible and solve the s				
United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	United Concordia Advantage Network Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) S1000 copay, per admission then 100% 70% after deductible for admission then 100% after deductible for admission then 100% after deductible for admission then 100% after deductible for after deductible for admission then 100% after deductible for after deductible for a few deductible for a		10	70 78	Not Covered
Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) spital Inpatient Solvation of the deductible for admission then 100% after deductible for a forward admission then 100% after deductible for a forwar	• • • • • • • • • • • • • • • • • • • •			
Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) Sapple Outpatient Tow after deductible Solve after deductible Solve after deductible Solve after deductible	Offiled Coffcordia Advantage Network			
Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Radiographs (all x-rays), Fluoride treatments, sealants) Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) Sapple Outpatient Tow after deductible Solve after deductible Solve after deductible Solve after deductible				
Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) Sepital Inpatient Solvation for admission then 100% after 100% after deductible 100% after deductible 50% a	Preventive Services (Exam, Cleanings,			
Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) Sepital Inpatient Solvation of the service o	Radiographs (all x-rays), Fluoride treatments,	10	10%	Not Covered
fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) Sepital Inpatient Solve after deductible admission then 100% after repair and provided and	staidilis)			
fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	fillings), resin based composite fillings (white fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) Sepital Inpatient Solve after deductible admission then 100% after repair and provided and	Basic Services (amalgam restarations (motal		1	
fillings)) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	fillings()) Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(s) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) Spital Inpatient Solvation of the standard	fillings) resin based composite fillings (white	5.	0%	Not Covered
Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) Not Covered	Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) \$1000 copay, per admission then 100% 70% after deductible 50% after deductible 100% after 100% after deductible 50% after deducti		3	~ /··	NOT COVERED
repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity)	repair, endodontic therapy (root canals, etc.)) Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) S1000 copay, per admission then 100% after deductible 100% after deducti	- ···			
Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) S1000 cents and maternity	Orthodontics(5) (Medically necessary with prior approval. Hospital and Medical/Surgical Expenses (including maternity) \$1000 copay, per admission then 100% after deductible 100% after deductible 100% after deductible 50% after deductible	iviajor Services (crowns, inlays, onlays, crown	5	0%	Not Covered
approval. Hospital and Medical/Surgical Expenses (including maternity)	approval. Hospital and Medical/Surgical Expenses (including maternity) \$1000 copay, per admission then 100% after deductible 100% after deductible 50% after deductible	Orthodontics(5) (Medically necessary with prior			
Hospital and Medical/Surgical Expenses (including maternity)	Hospital and Medical/Surgical Expenses (including maternity) \$1000 copay, per admission then 100% after deductible 100% after deductible 100% after deductible 50% after deductible 50% after deductible 50% after deductible 100% after deductib		5	0%	Not Covered
C1000 concurrer	Spital Inpatient \$1000 copay, per admission then 100% 70% after deductible 50% after deductible 100% after 70% after deductible 50% after deductible	Hospital and Med	lical/Surgical Expenses	s (including maternity)	
Innatient Provident Provident 70% after deductible 50% after deductible 50% after deductible	acrital Outrations 100% after 70% after deductible 50% after deductible		\$1000 copay, per		50% after deductible
		ioopiai iiipatioiit		, o , o anton deductible	5070 arter deductible
	TECHNOTICE I TO THE TECHNOLOGY OF CONTROL OF	Hospital Outpatient		70% after deductible	50% after deductible

Benefit	Network Out-of-Network		
	Enhanced Value	Standard Value	
Maternity (non-preventive facility services. Includes dependent daughter.)	100% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	70% after deductible	50% after deductible
	Emergency Service	98	
Emergency Room Services Ambulance	10	0% after \$250 Copay (wa 100% after enhanced	ived it admitted) deductible
Ambulance – Non-Emergency	100% after enhanced deductible	100% after enhanced deductible	100% after enhanced deductible
Therapy,	Rehabilitative and Habil	itative Services	
Physical Medicine (Rehabilitative and Habilitative)	100% after \$70 Copay	100% after \$90 Copay	50% after deductible
Physical Medicine – Benefit Maximum	apply to Habilitative	services for the treatmen Abuse diagnos	ts /benefit period - Limit does not t of a Mental Health or Substance sis
Respiratory Therapy	100% after deductible	70% after deductible	50% after deductible
Speech Therapy (Rehabilitative and Habilitative)	100% after \$70 Copay	100% after \$90 Copay	50% 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 \$70 Copay	100% after \$90 Copay	50% after deductible
Occupational Therapy – Benefit Maximum	apply to Habilitative	services for the treatmen e diagnosis Combined wit	ts /benefit period - Limit does not t of a Mental Health or Substance h Speech Therapy
Spinal Manipulations	100% after \$70 Copay	100% after \$90 Copay Limit: 20 visits/benef	50% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible	50% after deductible
M	ental Health/Substance		
Inpatient Detoxification/Rehabilitation	\$1000 copay, per a	idmission then 100% idmission then 100%	50% after deductible 50% after deductible
Outpatient Includes Virtual Behavioral Health Visits		r \$70 Copay	50% after deductible
Includes Viltual Deliaviolal Health Visits	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 \$350	70% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging,	Copay 100% after \$70	100% after	
diagnostic medical)	Copay	deductible and \$95 Copay 100% after	50% after deductible
Lab/Pathology	100% after \$70 Copay	deductible and \$95 Copay	50% after deductible
Durable Medical Equipment	100% after deductible	70% after deductible	50% after deductible
Orthotics and Prosthetics	100% after deductible	70% after deductible	50% after deductible
Home Health Care	100% after deductible	70% after deductible Limit: 60 visits/benef	50% after deductible
Haaniaa	100% after	70% after deductible	50% after deductible
Hospice	deductible Re	espite care limit of 7 days	
Infertility Counseling, Testing and Treatment(6)	100% after deductible	70% after deductible	50% after deductible
Skilled Nursing Facility Care	100% after deductible	70% after deductible	50% after deductible
Transplant Services	100% after	Limit: 120 days/bene	fit period 50% after deductible
Precertification Requirements(7)	deductible	YES	2070 Gitor Goddonino
	Prescription Drugs		
Prescription Drug Deductible Individual Family	None None		

Benefit Network Out-of-Network **Standard Enhanced Value** Value Retail Drugs (31/60/90-day Supply) \$3 / \$6 / \$9 low cost generic Copay --- \$15 /\$30 / \$45 generic Copay \$55 / \$110 / \$165 formulary brand Copay Prescription Drug Program(8) \$90 / \$180 / \$270 non-formulary Copay Soft Mandatory Generic Defined by the National Pharmacy Network - Not 20% formulary specialty coinsurance -- \$350 Maximum (31-day supply-Retail) 30% non-formulary specialty coinsurance -- \$500 Maximum (31-day supply-Retail) Physician Network. Prescriptions filled at a non-Maintenance Drugs through Mail Order (90-day Supply) \$3 low cost generic Copay -- \$15 standard generic Copay \$110 formulary brand Copay network pharmacy are not covered. Your plan uses the HCR Comprehensive Formulary \$180 non-formulary brand Copay 20% formulary specialty coinsurance -- \$700 Maximum (Mail Order) 30% non-formulary specialty coinsurance- \$1000 Maximum (Mail Order) with an Incentive Benefit Design.

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. (1) Contact your employer to determine the effective date applicable to your program.

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. Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may

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

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 depending on your group's prescription drug program.

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.

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.

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 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).

알링: 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 (ТТҮ): 711).

تتبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة 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.

U65_BCBS_G_M_1Col_8pt_blk_NL