Summary of Together Blue EPO $1500 *Benefits*

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network
General Provisions	
Benefit Period(1)	Contract Year
Deductible (per benefit period) Individual Family	 $1,500 $3,000
Plan Pays – payment based on the plan allowance	100% after deductible
Out-of-Pocket Limit (Includes deductible, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period.) Individual Family Plan	 $7,900 $15,800
Office/Clinic/Urgent Care Visits	
Retail Clinic Visits & Virtual Visits	100% after $30 copay
Primary Care Provider Office Visits & Virtual Visits	100% after $30 copay
Specialist Office & Virtual Visits	100% after $60 copay
Virtual Visit Originating Site Fee	100% after deductible
Urgent Care Center Visits	100% after $75 copay
Telemedicine Services(2)	100% after $15 copay
Preventive Care(3)	
Routine Adult	
Adult immunizations	100%
Colorectal cancer screening	100%
Diagnostic services and procedures	100%
Mammograms (annual routine)	100%
Mammograms(medically necessary)	100%
Physical exams	100%
Routine gynecological exams, including a Pap Test	100%
Routine adult vision screening	100%
Routine Pediatric	
Diagnostic services and procedures	100%
Pediatric immunizations	100%
Physical exams	100%
Pediatric Vision(4) - Davis Vision National Network	
Exam (including dilation, as professionally indicated)	100%
Pediatric frame selection	100%
Standard eyeglass lenses (per pair)	100%
Pediatric Dental(4) - United Concordia Advantage Network	
Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants)	100%
Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings))	50%
Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.))	50%
Orthodontics(5) (Medically necessary with prior approval)	50%
Hospital and Medical/Surgical Expenses (including maternity)	
Hospital Inpatient	100% after deductible
Hospital Outpatient (Non-Surgical)	100% after deductible
Outpatient Surgery (8)	100% after deductible
Maternity (non-preventive facility services) including dependent daughter	100% after deductible
Medical Care (including inpatient visits and consultations) **/Surgical Expenses**	100% after deductible
Emergency Services	
Emergency Room Services	100% after $300 copay (waived if admitted)
Ambulance	100% after in-network deductible
Ambulance – Non-Emergency	100% after deductible
Therapy, Rehabilitative and Habilitative Services	
Physical Medicine (Rehabilitative and Habilitative)	100% after $60 copay
Physical Medicine- Benefit Maximum - Combined with Occupational Therapy	Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to Habilitative services for the treatment of a Mental Health or Substance Abuse diagnosis
Respiratory Therapy	100% after deductible
Speech Therapy (Rehabilitative and Habilitative)	100% after $60 copay
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
Occupational Therapy (Rehabilitative and Habilitative)	100% after $60 copay

(8) Benefit	Network
Occupational Therapy- Benefit Maximum - Combined with Physical Therapy	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
Spinal Manipulations	100% after $60 copay
Spinal Manipulations- Benefit Maximum	Limit: 20 visits/benefit period
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible
Mental Health/Substance Abuse	
Inpatient	100% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible
Outpatient **Includes Virtual Behavioral Health Visits**	100% after $60 copay
Other Services	
Allergy Extracts and Injections	100% after deductible
Assisted Fertilization Procedures (limited to artificial insemination)	100% after deductible
Dental Services Related to Accidental Injury	100% after deductible
Diagnostic Services	
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after $300 copay
Basic Diagnostic Services (standard imaging, diagnostic medical)	100% after $60 copay
Lab/Pathology	100% after $60 copay
Durable Medical Equipment	100% after deductible
Orthotics and Prosthetics	100% after deductible
Home Health Care	100% after deductible Limit: 60 visits/benefit period
Hospice	100% after deductible Respite care limit of 7 days every 6 months
Infertility Counseling, Testing and Treatment (6)	100% after deductible
Skilled Nursing Facility Care	100% after deductible Limit: 120 days/benefit period
Transplant Services	100% after deductible
Precertification Requirements	YES
Prescription Drugs	
Prescription Drug Deductible Individual Family	 None None
Prescription Drug Program(7) *Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Essential Formulary with a Closed Benefit Design.*	**Retail Drugs (31/60/90-day Supply)** Tier 1: $0 / $0 / $0 copay Tier 2: $25 / $50 / $75 copay Tier 3: $75 / $150 / $225 copay Tier 4: 50% -- $250 min - $1,000 max / $500 min - $2,000 max / $750 min - $3,000 max **Maintenance Drugs through Mail Order (90-day Supply)** Tier 1: $0 copay Tier 2: $50 copay Tier 3: $150 copay Tier 4: 50% - $500 min -- $2,000 max

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health / Substance Abuse benefit.
(3) Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
(4) Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.
(5) A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality. Prior approval is required. See your benefit booklet for more details.
(6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(7) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. To obtain a prescription medication that is not included on this formulary, your provider must complete the 'Prescription Drug Medication Request Form' and return it to the Pharmacy Affairs Department for clinical review.
Refers to outpatient surgical procedure provided in a hospital or ambulatory facility setting.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Coverage Advantage, Highmark Select Resources, 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).

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).

تنبيه: 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.

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