Summary of PPO Blue $0 100/80 Platinum *Benefits*

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

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $0 $0	 $500 $1,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes deductible, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period.) Individual Family	 $4,000 $8,000	 $8,000 $16,000
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $20 copay	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $20 copay	80% after deductible
Specialist Office & Virtual Visits	100% after $35 copay	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $40 copay, the copayment, if any, does not apply to urgent care services prescribed for the treatment of mental illness or substance abuse	80% after deductible
Preventive Care(2)		
Routine Adult		
Adult immunizations	100%	80% after deductible
Colorectal cancer screening	100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
Mammograms(annual routine)	100%	80% after deductible
Mammograms (medically necessary)	100%	80% after deductible
Physical exams	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100%	80%
Routine adult vision Screening	100%	Not Covered
Routine Pediatric		
Diagnostic services and procedures	100%	80% after deductible
Pediatric immunizations	100%	80%
Physical exams	100%	80% after deductible
Pediatric Vision(3) - **Davis Vision National Network**		
Exam (including dilation, as professionally indicated)	100%	Not Covered
Pediatric frame selection	100%	Not Covered
Standard eyeglass lenses (per pair)	100%	Not Covered
Contact Lens Benefit (in lieu of eyeglasses)		
Evaluation, Fitting & Follow-up Care	100%	Not Covered
Collection Contact Lenses (Disposable; Planned Replacement)	100%	Not Covered
Non-Collection Contact Lenses: Materials Allowance	$150 discounted price	Not Covered
Evaluation, Fitting & Follow-up Care – Standard lens Types and Specialty Lens Types	Not Covered	Not Covered
Pediatric Dental(3) - United Concordia Advantage Network		
Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants)	100%	Not Covered
Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings))	50%	Not Covered
Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.))	50%	Not Covered
Orthodontics(4) (Medically necessary with prior approval)	50%	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient (Non-Surgical)	100% after deductible	80% after deductible
Outpatient Surgery (8)	100% after deductible	80% after deductible
Maternity (non-preventive facility) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)**/Surgical Expenses**	100% after deductible	80% after deductible
Emergency Services		
Emergency Room Services	100% after $150 copay (waived if admitted)	
Ambulance (9)	100% after in-network deductible	
Ambulance – Non-Emergency (10)	100% after deductible	80% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Medicine (Rehabilitative and Habilitative)	100% after $35 copay	80% after deductible

Benefit	Network	Out-of-Network
Physical Medicine – Benefit Maximum - Combined with Occupational Therapy	Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to therapy services for the treatment of a Mental Health or Substance Abuse diagnosis	
Respiratory Therapy	100% after deductible	80% after deductible
Speech Therapy (Rehabilitative and Habilitative)	100% after $35 copay	80% after deductible
Speech Therapy- Benefit Maximum	Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to therapy services for the treatment of a Mental Health or Substance Abuse diagnosis	
Occupational Therapy (Rehabilitative and Habilitative)	100% after $35 copay	80% after deductible
Occupational Therapy – Benefit Maximum - Combined with Physical Therapy	Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to therapy services for the treatment of a Mental Health or Substance Abuse diagnosis	
Spinal Manipulations	100% after $35 copay	80% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health/Substance Abuse		
Inpatient	100% after deductible	80% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	80% after deductible
Outpatient Includes Virtual Behavioral Health Visits	100% after $35 copay	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Artificial Insemination	100% after deductible	80% after deductible
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diabetes Care Management Program (Digitally Monitored)	100%	Not Covered
	Continuous glucose monitor sprints are limited to three (3) per benefit period	
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after $75 copay, the copayment, if any, does not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical)	100% after $35 copay, the copayment, if any, does not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse	80% after deductible
Lab/Pathology	100% after $35 copay, the copayment, if any, does not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse	80% after deductible
Durable Medical Equipment	100% after deductible	80% after deductible
Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	Limit: 60 visits/benefit period	
House Call Program	100%	Not Covered
	Limited to one (1) per benefit period	
Hospice	100% after deductible	80% after deductible
	Respite care limit of 7 days every 6 months	
Infertility Counseling, Testing and Treatment(5)	100% after deductible	80% after deductible
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	Limit: 120 days/benefit period	
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements(6)	YES	
Prescription Drugs		
Prescription Drug Deductible Individual Family	None None	
Prescription Drug Program(7) Soft Mandatory Generic *Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the HCR Comprehensive Formulary with an Incentive Benefit Design.*	**Retail Drugs (31/60/90-day Supply)** $3 / $6 / $9 low cost generic copay -- $10 / $20 / $30 standard generic copay $50 / $100 / $150 formulary brand copay $85 / $170 / $255 non-formulary copay 20% formulary specialty coinsurance -- $350 Maximum (31-day supply-Retail) 30% non-formulary specialty coinsurance -- $500 Maximum (31-day supply-Retail) **Maintenance Drugs through Mail Order (90-day Supply)** $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) 30% non-formulary specialty coinsurance -- $1000 Maximum (Mail Order)	

To access more information about the drug formulary, including tiering, please go to https://www.highmark.com/content/dam/digital-marketing/en/highmark/highmarkdotcom/pdfs/quality-assurance/CS204330_NCQAPreSale_BRO_BCBS_R2.pdf or for a paper copy, call 1-855-873-4106.