Summary of Premier Balance PPO $0 Platinum A *Benefits*

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

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual 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	80% after deductible
Telemedicine Services(2)	100% after $15 copay	Not Covered
Preventive Care(3)		
Routine Adult		
Adult immunizations	100%	80% after deductible
Colorectal cancer screening	100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
Mammograms(annual routine)	100%	80% after deductible
Mammograms (medically necessary)	100%	80% after deductible
Physical exams	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100%	80%
Routine adult vision Screening	100%	Not Covered
Routine Pediatric		
Diagnostic services and procedures	100%	80% after deductible
Pediatric immunizations	100%	80%
Physical exams	100%	80% after deductible
Pediatric Vision(4) - **Davis Vision National Network**		
Exam (including dilation, as professionally indicated)	100%	Not Covered
Pediatric frame selection	100%	Not Covered
Standard eyeglass lenses (per pair)	100%	Not Covered
Pediatric Dental(4) - United Concordia Advantage Network		
Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants)	100%	Not Covered
Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings))	50%	Not Covered
Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.))	50%	Not Covered
Orthodontics(5) (Medically necessary with prior approval)	50%	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient (Non-Surgical)	100% after deductible	80% after deductible
Outpatient Surgery (9)	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	100% after in-network deductible	
Ambulance – Non-Emergency	100% after deductible	80% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Medicine (Rehabilitative and Habilitative)	100% after $35 copay	80% after deductible
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	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 Habilitative services for the treatment of a Mental Health or Substance Abuse diagnosis	
Occupational Therapy (Rehabilitative and Habilitative)	100% after $35 copay	80% after deductible

Benefit	Network	Out-of-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 $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
Assisted Fertilization Procedures (limited to artificial insemination)	100% after deductible	80% after deductible
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after $75 copay	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical)	100% after $35 copay	80% after deductible
Lab/Pathology	100% after $35 copay	80% after deductible
Durable Medical Equipment	100% after deductible	80% after deductible
Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	Limit: 60 visits/benefit period	
Hospice	100% after deductible	80% after deductible
	Respite care limit of 7 days every 6 months	
Infertility Counseling, Testing and Treatment(6)	100% after deductible	80% after deductible
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(7)	YES	
Prescription Drugs		
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.* *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)	

(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) Be sure your provider is aware that Highmark Utilization Management must be contacted for authorization prior to a planned inpatient admission or within 48 hours of an emergency or unplanned inpatient admission. Also note that certain outpatient procedures require prior authorization. If authorization is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate you will be responsible for the payment of any costs not covered by your health plan.
(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 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.
(9) 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 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

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

Summary of Premier Balance PPO $1000 A *Benefits*

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

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 $1,000 $2,000	 $2,000 $4,000
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	 $7,900 $15,800	 $15,800 $31,600
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $30 copay	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $30 copay	80% after deductible
Specialist Office & Virtual Visits	100% after $60 copay	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $75 copay	80% after deductible
Telemedicine Services(2)	100% after $15 copay	Not Covered
Preventive Care(3)		
Routine Adult		
Adult immunizations	100%	80% after deductible
Colorectal cancer screening	100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
Mammograms(annual routine)	100%	80% after deductible
Mammograms (medically necessary)	100%	80% after deductible
Physical exams	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100%	80%
Routine adult vision Screening	100%	Not Covered
Routine Pediatric		
Diagnostic services and procedures	100%	80% after deductible
Pediatric immunizations	100%	80%
Physical exams	100%	80% after deductible
Pediatric Vision(4) **-** **Davis Vision National Network**		
Exam (including dilation, as professionally indicated)	100%	Not Covered
Pediatric frame selection	100%	Not Covered
Standard eyeglass lenses (per pair)	100%	Not Covered
Pediatric Dental(4) **-** United Concordia Advantage Network		
Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants)	100%	Not Covered
Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings))	50%	Not Covered
Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.))	50%	Not Covered
Orthodontics(5) (Medically necessary with prior approval)	50%	Not Covered
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient (Non-Surgical)	100% after deductible	80% after deductible
Outpatient Surgery (9)	100% after deductible	80% after deductible
Maternity (non-preventive facility) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)**/Surgical Expenses**	100% after deductible	80% after deductible
Emergency Services		
Emergency Room Services	100% after $300 copay (waived if admitted)	
Ambulance	100% after in-network deductible	
Ambulance – Non-Emergency	100% after deductible	80% after deductible
Therapy, Rehabilitative and Habilitative Services		
Physical Medicine (Rehabilitative and Habilitative)	100% after $60 copay	80% after deductible
Physical Medicine – Benefit Maximum - 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	80% after deductible
Speech Therapy (Rehabilitative and Habilitative)	100% after $60 copay	80% after deductible
Speech Therapy- Benefit Maximum	Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to Habilitative services for the treatment of a Mental Health or Substance Abuse diagnosis	
Occupational Therapy (Rehabilitative and Habilitative)	100% after $60 copay	80% after deductible

Benefit	Network	Out-of-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	80% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health/Substance Abuse		
Inpatient	100% after deductible	80% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	80% after deductible
Outpatient Includes Virtual Behavioral Health Visits	100% after $60 copay	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Assisted Fertilization Procedures (limited to artificial insemination)	100% after deductible	80% after deductible
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after $300 copay	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical)	100% after $60 copay	80% after deductible
Lab/Pathology	100% after $60 copay	80% after deductible
Durable Medical Equipment	100% after deductible	80% after deductible
Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
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Precertification Requirements(7)	YES	
Prescription Drugs		
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.* *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 --- $15 /$30 / $45 generic copay $55 / $110 / $165 formulary brand copay $90 / $180 / $270 non-formulary copay 20% formulary specialty coinsurance -- $350 Maximum (31-day supply-Retail) 30% non-formulary specialty coinsurance -- $500 Maximum (31-day supply-Retail) **Maintenance Drugs through Mail Order (90-day Supply)** $3 low cost generic copay -- $15 standard generic copay $110 formulary brand copay $180 non-formulary brand copay 20% formulary specialty coinsurance -- $700 Maximum (Mail Order) 30% non-formulary specialty coinsurance- $1000 Maximum (Mail Order)	

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