

# Summary of High Deductible PPO \$3500 Qualified A a Community Blue Flex Plan Benefits

(This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA).) 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.

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
<b>General Provisions</b>			
<b>Benefit Period</b> (1)	Contract Year		
<b>Deductible</b> (per benefit period) (All in-network services are credited to both the standard and the enhanced deductibles.)			
Individual	\$3,500		\$10,500
Family	\$7,000		\$21,000
<b>Plan Pays</b> – payment based on the plan allowance	100% after deductible	70% after deductible	50% after deductible
<b>Out-of-Pocket Limit</b> (Includes deductible, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period.)			
Individual	\$6,450		\$19,350
Family	\$12,900		\$38,700
<b>Office/Clinic/Urgent Care Visits</b>			
<b>Retail Clinic Visits</b>	\$25 copayment after deductible	\$55 copayment after deductible	50% after deductible
<b>Primary Care Provider Office Visits</b>	\$25 copayment after deductible	\$55 copayment after deductible	50% after deductible
<b>Specialist Office &amp; Virtual Visits</b>	\$45 copayment after deductible	\$75 copayment after deductible	50% after deductible
Virtual Visit Originating Site Fee	100% after deductible	70% after deductible	50% after deductible
<b>Urgent Care Center Visits</b>	\$75 copayment after deductible	\$100 copayment after deductible	50% after deductible
<b>Telemedicine Service</b> (2)	100% after deductible		
<b>Preventive Care</b> (3)			
<b>Routine Adult</b>			
Adult immunizations	100% (deductible does not apply)		50% after deductible
Colorectal cancer screening	100% (deductible does not apply)		50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% after deductible		50% after deductible
Physical exams	100% (deductible does not apply)		50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)		50% (deductible does not apply)
Routine adult vision exam	Not Covered		
<b>Routine Pediatric</b>			
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Pediatric immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Physical exams	100% (deductible does not apply)		50% after deductible
<b>Pediatric Vision</b> (4) - <b>Davis Vision National Network</b>			
Exam (including dilation, as professionally indicated)	100% (deductible does not apply)		Not Covered
Pediatric frame selection	100% after enhanced deductible		Not Covered
Standard eyeglass lenses (per pair)	100% after enhanced deductible		Not Covered
<b>Pediatric Dental</b> (4) - <b>United Concordia Advantage Network</b>			
Exam and Cleanings	100% (deductible does not apply)		Not Covered
Basic Services (Fluoride treatments, sealants, consultations)	100% after enhanced deductible		Not Covered

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Major Services (Radiographs (all x-rays), space maintainers, amalgam restorations (metal fillings), resin based composite fillings (white fillings), crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.))	100% after enhanced deductible		Not Covered
Orthodontics <sup>(5)</sup> (Medically necessary with prior approval. Waiting limits apply.)	100% after enhanced deductible		Not Covered
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>			
<b>Hospital Inpatient</b>	100% after deductible	70% after deductible	50% after deductible
<b>Hospital Outpatient</b>	100% after deductible	70% after deductible	50% after deductible
<b>Maternity</b> (non-preventive facility & professional services. Includes dependent daughter.)	100% after deductible	70% after deductible	50% after deductible
<b>Medical Care</b> (including inpatient visits and consultations)/ <b>Surgical Expenses</b>	100% after deductible	70% after deductible	50% after deductible
<b>Emergency Services</b>			
<b>Emergency Room Services</b>	\$150 copayment after deductible (waived if admitted)		
<b>Ambulance</b>	100% after enhanced deductible		
<b>Ambulance – Non-Emergency</b>	100% after enhanced deductible		
<b>Therapy, Rehabilitative and Habilitative Services</b>			
<b>Physical Medicine</b> (Rehabilitative and Habilitative)	\$45 copayment after deductible	\$75 copayment after deductible	50% after deductible
	Limit: 30 combined rehab/habilitative visits/benefit period		
<b>Respiratory Therapy</b>	100% after deductible	70% after deductible	50% after deductible
<b>Speech &amp; Occupational Therapy</b> (Rehabilitative and Habilitative)	\$45 copayment after deductible	\$75 copayment after deductible	50% after deductible
	Limit: 30 combined rehab/habilitative visits per therapy/benefit period		
<b>Spinal Manipulations</b>	\$45 copayment after deductible	\$75 copayment after deductible	50% after deductible
	Limit: 20 visits/benefit period		
<b>Other Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible	50% after deductible
<b>Mental Health/Substance Abuse</b>			
<b>Inpatient</b>	100% after enhanced deductible		50% after deductible
<b>Inpatient Detoxification/Rehabilitation</b>	100% after enhanced deductible		50% after deductible
<b>Outpatient</b>	\$45 copayment after deductible		50% after deductible
<b>Other Services</b>			
<b>Allergy Extracts and Injections</b>	100% after deductible	70% after deductible	50% after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered		
<b>Dental Services Related to Accidental Injury</b>	Not Covered		
<b>Diagnostic Services</b>			
<i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	\$200 copayment after deductible	\$400 copayment after deductible	50% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	\$45 copayment after deductible	\$75 copayment after deductible	50% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100% after deductible	70% after deductible	50% after deductible
<b>Home Health Care</b>	100% after deductible	70% after deductible	50% after deductible
	Limit: 90 visits/benefit period		
<b>Hospice</b>	100% after deductible	70% after deductible	50% after deductible
<b>Infertility Counseling, Testing and Treatment<sup>(6)</sup></b>	100% after deductible	70% after deductible	50% after deductible
<b>Private Duty Nursing</b>	100% after deductible	70% after deductible	50% after deductible
	Limit: 240 hours/benefit period		
<b>Skilled Nursing Facility Care</b>	100% after deductible	70% after deductible	50% after deductible
	Limit: 120 days/benefit period		
<b>Transplant Services</b>	100% after deductible	70% after deductible	50% after deductible
<b>Precertification Requirements<sup>(7)</sup></b>	YES		
<b>Prescription Drugs</b>			
<b>Prescription Drug Deductible</b> Individual Family	Combined with medical Combined with medical		

\*The terms "enhanced value" and "standard value" are not descriptors of the provider's ability. This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.  
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<p><b>Prescription Drug Program<sup>(8)</sup></b> Soft Mandatory Generic <i>Defined by the Premier 2012 Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i></p> <p><i>Your plan uses the HCR Comprehensive Formulary with an Incentive Benefit Design.</i></p>	<p align="center"><b>Retail Drugs (31/60/90-day Supply)</b></p> <p>\$3 / \$6 / \$9 low cost generic copayment after deductible--- \$8 /\$16 / \$24 generic copayment after deductible</p> <p>\$40 / \$80 / \$120 formulary brand copayment after deductible \$70 / \$140 / \$210 non-formulary copayment after deductible</p> <p align="center"><b>Maintenance Drugs through Mail Order (90-day Supply)</b></p> <p>\$8 low cost generic copayment after deductible -- \$20 generic copayment after deductible</p> <p>\$100 formulary brand copayment after deductible \$175 non-formulary brand copayment after deductible</p>		

- (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 must be performed by a Highmark approved telemedicine provider.
- (3) Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
- (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. 12 month waiting period 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) Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (8) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary 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.