HIGHMARK. Performance Flex Blue PPO

Hazleton Area SD Performance $500 Flex Blue PPO

Groups: 10822209,10822210,10822211,10822212,10822213,10822214,10822215,10822216,10822217,10822218, 10822220,10822221,10822222,10822223,10822224

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 at the Enhanced Value level of benefits, 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	
General Provisions			
Effective Date	01/01/2027		
Benefit Period (1)	Calendar Year		
Deductible (per benefit period) (All in-network services are credited to both the enhanced and the standard deductibles.)			
Individual	$250	$500	$1,000
Family	$750	$1,500	$3,000
Plan Pays/Coinsurance – payment based on the plan allowance	100% after deductible	100% after deductible	80% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period) (All in-network services are credited to both the enhanced and the standard out-of-pocket limits.)			
Individual	None	None	None
Family	None	None	None
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copayments, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.			
Individual	**$6,600**		Not Applicable
Family	**$13,200**		Not Applicable
Bi-Directional	CVS Caremark TMOOP		
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after $10 copayment	100% after $15 copayment	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $10 copayment	100% after $15 copayment	80% after deductible
Specialist Office Visits & Virtual Visits	100% after $15 copayment	100% after $30 copayment	80% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $15 copayment	100% after $30 copayment	80% after deductible
	copay, if any, does not apply to urgent care center visits prescribed for the treatment of mental health or substance abuse		
On-Demand Telemedicine Services	Not Covered		Not Covered
Preventive Care(3)			
Routine Adult Physical Exams	100% (deductible does not apply)	100% (deductible does not apply)	80% after deductible
Adult immunizations	100% (deductible does not apply)	100% (deductible does not apply)	80% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Breast Cancer Screenings	100% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	100% (deductible does not apply)	80% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Prostate Cancer Screening	100% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Nutritional Therapy	100% (deductible does not apply)	100% (deductible does not apply)	80% after deductible
	Benefit Limit: 6 visits/benefit period		
Diagnostic services and procedures	100% (deductible does not apply)	100% (deductible does not apply)	80% after deductible
Routine Pediatric Physical exams	100% (deductible does not apply)	100% (deductible does not apply)	80% after deductible
Pediatric immunizations	100% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	100% (deductible does not apply)	80% after deductible
Hospital and Medical/Surgical Expenses (including maternity)(5)			
Hospital Inpatient	100% after deductible	100% after deductible	80% after deductible
Hospital Outpatient (Non-Surgical)	100% after deductible	100% after deductible	80% after deductible
Outpatient Surgery (facility)	100% after deductible	100% after deductible	80% after deductible
Surgical Services (professional)	100% after deductible	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	100% after deductible	80% after deductible
Emergency Services			
Emergency Room Services (4)	100% after $100 copayment (waived if admitted)		
Ambulance – Emergency	100% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Ambulance – Non-Emergency (5)	80% after deductible	80% after deductible	80% after deductible
Therapy and Rehabilitation Services			
Physical Medicine	$15 copayment after deductible	$30 copayment after deductible	80% after deductible
	Benefit Limit: 45 visits/benefit period aggregate with speech therapy and occupational therapy-limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse		
Respiratory Therapy	100% after deductible	100% after deductible	80% after deductible
	Benefit Limit: 18 visits/benefit period		
Speech Therapy	$15 copayment after deductible	$30 copayment after deductible	80% after deductible
	Benefit Limit: 45 visits/benefit period aggregate with occupational therapy and physical medicine-limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse		
Occupational Therapy	$15 copayment after deductible	$30 copayment after deductible	80% after deductible
	Benefit Limit: 45 visits/benefit period aggregate with speech therapy and physical medicine-limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse		
Spinal Manipulations	100% after $5 copayment	100% after $15 copayment	80% after deductible
	Benefit Limit: 15 visits/benefit period no age limits		
Cardiac Rehabilitation Therapy	100% after deductible	100% after deductible	80% after deductible
	Benefit Limit: 36 visits/benefit period		
Other Therapy Services (Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	100% after deductible	80% after deductible
Mental Health/Substance Abuse			
Inpatient Mental Health Services	100% after deductible	100% after enhanced deductible	80% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	100% after enhanced deductible	80% after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	100% after deductible	100% after enhanced deductible	80% after deductible
Outpatient Substance Abuse	100% after deductible	100% after enhanced deductible	80% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	100% after deductible	80% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (6)	100% after deductible	100% after deductible	80% after deductible
	Benefit Limit: $40,000 annual limit		

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	100% after deductible	100% after deductible	80% after deductible
Dental Services Related to Accidental Injury (8)	100% after deductible	100% after deductible	80% after deductible
Diabetes Treatment Equipment and Supplies	100% after deductible	100% after deductible	80% after deductible
Diabetes Education Program	100% after deductible	100% after deductible	80% after deductible
Advanced Imaging (MRI, CAT, PET scan, etc.)	$75 copay after deductible	$75 copay after deductible	80% after deductible
	Benefit Limit: Copay is per test. The $75 copay does not apply to services provided by the following providers: Vision Imaging of Kingston-001655538, Schuylkill Imaging 005144427		
	copays, if any, do not apply to diagnostic services prescribed for the treatment of mental health or substance abuse		
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	100% after deductible	80% after deductible
Enteral Foods	100% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Home Health Care	100% after $15 copay	$30 copayment after deductible	80% after deductible
	Benefit Limit: unlimited		
Home Infusion and Suite Infusion Therapy	100% after deductible	100% after deductible	80% after deductible
Hospice	100% after deductible	100% after deductible	80% after deductible
	Benefit Limit: 180 days/ lifetime and respite care maximum of 5 days for every 3 months		
Infertility Counseling, Testing and Treatment (8)	100% after deductible	100% after deductible	80% after deductible
	Benefit Limit: Diagnostic services leading up to the diagnosis of infertility.		
Mammograms, Medically Necessary	100% (deductible does not apply)	100% (deductible does not apply)	80% (deductible does not apply)
Private Duty Nursing	Not covered	Not covered	Not covered
Skilled Nursing Facility Care	100% after deductible	100% after deductible	80% after deductible
	Benefit Limit: 100 days/benefit period		
Therapeutic Injections	100% after deductible	100% after deductible	80% after deductible
Transplant Services (8)	100% after deductible	100% after deductible	80% after deductible
Precertification/Authorization Requirements (7)	Yes		

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy / plan documents, as limitations and exclusions apply. The policy / plan documents control in the event of a conflict with this benefit summary.

**The terms "Enhanced Value" and "Standard Value" are not descriptors of the provider's ability.*

1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government, TMOOP must include deductible, coinsurance, copayments, prescription drug cost share and any qualified medical expense. With your aggregate TMOOP, once an individual's TMOOP is satisfied, claims will pay at 100% of the plan allowance for covered expenses for the rest of the benefit period. Claims for the remaining family members will pay at 100% once the family TMOOP amount is satisfied collectively.
3) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
4) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
5) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
6) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services-Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g. speech therapy, diagnostic services). Services for the treatment of Autism Spectrum Disorders do not reduce visit/day limits.

7) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient

admission to obtain any required precertification. If precertification 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) Covered Services will be covered according to the benefit category to which they apply (e.g. outpatient surgery, hospital inpatient, diagnostic services).

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield, First Priority Health or First Priority Life, all of which are independent licensees of the Blue Cross Blue Shield Association.

Discrimination is Against the Law

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- 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 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.

Please note that your plan sponsor – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/program.

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).

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).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (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).

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).

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).

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.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 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).

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក (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).

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).

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.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दनिुहोस्: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। तपाईंको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).