Summary of CommunityBlue Flex PPO

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.

Local Roofers Union #210 **Group 017766-00, 70**

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
General Provisions			
Benefit Period(1)	Calendar Year		
Deductible (per benefit period) (All in-network services are credited to both the enhanced and the standard deductibles.) Individual Family	 $2,500 $5,000	 $5,000 $10,000	 $10,000 $20,000
Plan Pays – payment based on the plan allowance	80% after deductible	60% after deductible	50% after deductible
Out-of-Pocket Limit (Once met, plan pays100% coinsurance for the rest of the benefit period) (All in-network services are credited to both the standard and the enhanced out-of-pocket limits) Individual Family	 $3,500 $7,000	 $7,000 $14,000	 $14,000 $28,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, 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 Family	 $7,350 $14,700		 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after $25 copay	100% after $50 copay	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $25 copay	100% after $50 copay	50% after deductible
Specialist Office Visits & Virtual Visits	100% after $50 copay	100% after $100 copay	50% after deductible
Virtual Visit Originating Site Fee	100% after deductible	70% after deductible	50% after deductible
Urgent Care Center Visits	100% after $25 copay	100% after $50 copay	50% after deductible
Telemedicine Services (3)	not covered	not covered	not covered
Preventive Care (4)			
Routine Adult Physical Exams	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Adult Immunizations	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Routine Pediatric Physical Exams	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Pediatric Immunizations	100% (deductible does not apply)	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Emergency Services			
Emergency Room Services	100% after $250 copay (waived if admitted)		
Ambulance - Emergency and Non-Emergency	100% after deductible	100% after enhanced deductible	
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	100% after deductible	70% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	70% after deductible	50% after deductible
Therapy and Rehabilitation Services			
Physical Medicine	100% after $50 copay	100% after $100 copay limit: 20 visits/benefit period	50% after deductible
Respiratory Therapy	100% after deductible	70% after deductible	50% after deductible
Speech Therapy	100% after $50 copay	100% after $100 copay limit: 20 visits/benefit period	50% after deductible
Occupational Therapy	100% after $50 copay	100% after $100 copay	50% after deductible

Benefit	In-Network Enhanced Value	In-Network Standard Value	Out of Network
	limit: 20 visits/benefit period		
Spinal Manipulations	100% after $50 copay	100% after $100 copay	50% after deductible
	limit: 20 visits/benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible	50% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	100% after deductible	100% after enhanced deductible	50% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	100% after enhanced deductible	50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after deductible	100% after enhanced deductible	50% after deductible
Outpatient Substance Abuse Services	100% after deductible	100% after enhanced deductible	50% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	70% after deductible	50% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (5)	100% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	not covered	not covered	not covered
Dental Services Related to Accidental Injury	100% after deductible	70% after deductible	50% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	70% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	70% after deductible	50% after deductible
Home Health Care	100% after deductible	70% after deductible	50% after deductible
Hospice	100% after deductible	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment (6)	100% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	70% after deductible	50% after deductible
	limit: 240 hours/benefit period		
Skilled Nursing Facility Care	100% after deductible	70% after deductible	50% after deductible
Transplant Services	100% after deductible	70% after deductible	50% after deductible
Precertification Requirements (7)	Yes	Yes	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 Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (31-day/60-day/90-day Supply)** $10/$20/$30 generic copay $40/$80/$120 Formulary brand copay $75/$150/$225 Non-Formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $20 generic copay $80 Formulary brand copay $150 Non-Formulary brand copay		

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 benefits 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, copays, prescription drug cost share and any qualified medical expense.
(3) 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 benefit.
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Coverage for eligible members to age 21. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
(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) Highmark 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 Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed.