Customized Community Blue Flex PPO Sharing $4,000 $30/$40 Rx G Benefit Summary

With Community Blue Flex, 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	
General Provisions			
Benefit Period(1)	Contract Year		
Deductible (per benefit period)(All in-network services are credited to both the standard and the enhanced deductibles.) Individual Family	 $4,000 $8,000	 $6,000 $12,000	 $10,000 $20,000
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible	50% 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 standard and the enhanced out-of-pocket limits) Individual Family	 None None	 $500 $1,000	 $10,000 $20,000
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 $30 copay	100% after $50 copay	50% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $30 copay	100% after $50 copay	50% after deductible
Specialist Office & Virtual Visits	100% after $40 copay	100% after $75 copay	50% after deductible
Virtual Visit Originating Site Fee	100% after deductible	70% after deductible	50% after deductible
Urgent Care Center Visits	100% after $75 copay	100% after $100 copay	50% after deductible
Telemedicine Services(3)	100% after $20 copay		Not Covered
Preventive Care(4)			
Routine Adult Physical exams	100% (deductible does not apply)		50% after deductible
Adult immunizations	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)
Mammograms, annual routine	100% (deductible does not apply)		50% after deductible
Mammograms, medically necessary	100% (deductible does not apply)		50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Routine Pediatric Physical exams	100% (deductible does not apply)		50% after deductible
Pediatric immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)		50% after 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
Emergency Services			
Emergency Room Services	100% after $150 copay (waived if admitted)		
Ambulance – Emergency	100% after enhanced deductible		
Ambulance – Non-Emergency	100% after enhanced deductible		
Therapy and Rehabilitation Services			
Physical Medicine	100% after $40 copay	100% after $75 copay	50% after deductible
	Limit: 20 visits/benefit period		
Speech & Occupational Therapy	100% after $40 copay	100% after $75 copay	50% after deductible
	Limit: 20 visits per therapy/benefit period		

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Therapy and Rehabilitation Services (cont.)			
Respiratory Therapy	100% after deductible	70% after deductible	50% after deductible
Spinal Manipulations	100% after $40 copay	100% after $75 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 enhanced deductible		50% after deductible
Inpatient Detoxification / Rehabilitation	100% after enhanced deductible		50% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after $40 copay		50% after deductible
Outpatient Substance Abuse Services	100% after $40 copay		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	Not Covered	Not Covered	Not Covered
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
	Limit: 90 visits/benefit period		
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
	Limit: 100 days/benefit period		
Transplant Services	100% after deductible	70% after deductible	50% 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 Comprehensive Formulary with an Incentive Benefit Design.	**Retail Drugs (31/60/90-day Supply)** $8/$16/$24 generic copay $40/$80/$120 formulary brand copay $70/$140/$210 non-formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $20 generic copay $100 formulary brand copay $175 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 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) 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.

HIGHMARK® Blue Cross Blue Shield

An Independent Licensee of the Blue Cross and Blue Shield Association

HOW TO COMPLETE YOUR HIGHMARK BLUE CROSS BLUE SHIELD ENROLLMENT APPLICATION

Following are instructions for completing the Highmark Blue Cross Blue Shield Enrollment Application. All information must be completed as indicated.

EMPLOYEE INFORMATION

The first thirteen (13) items ask for information regarding the employee. The information you must complete includes:

1) Employer Name and Reason for Application

2) Employee First Name, Middle Initial, Last Name.

3) Employee Street Address

4) City

5) State

6) Zip Code

7) Employee Social Security Number

8) Effective Date of Coverage

9) Employee Status: Please check (✓) the appropriate box indicating whether you are an Active, Retired, Hourly or Salary employee. If retired, please indicate retirement date.

10) Employee Home Phone Number (including area code) – Please provide so that we may contact you if we have questions about your application and to better serve you.

11) Employee Work Phone Number (including area code)

12) Employee Hire Date (i.e., date employee first eligible to enroll for benefits) – Specify month/day/year. Required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

13) Check Type of Coverage for which you are enrolling, using the appropriate category (employee, two person or family).

14) To be completed by Account/Administrator only

Items **15** through **19** ask for important information about yourself and each eligible member of your family (**15** yourself, **16** your spouse/ domestic partner, **17-19** your dependents). Please complete all requested information. If relationship is “other”, please indicate the dependent’s relationship to the employee according to the codes provided on the application.

- **First Name/Middle Initial/Last Name** — Complete the First Name, Middle Initial and Last Name for each eligible person listed.
- **Social Security Number** — Please include the Social Security Number of each person.
- **Do you have other insurance?** — If you or a family member have other medical insurance including Medicare, respond “yes”. If not, you must respond “No”.
- **Birth Date** (month/day/year)
- **Sex** (female or male)
- **Check if: Student over 19, Disabled and/or Act 4 dependent** — If your dependent is over the age of 19 and a full time student or a disabled dependent of any age or an Act 4 dependent to the age of 30 (see your benefit administrator for eligibility), please check (✓) the appropriate column by that dependent’s name.

20) Needs to be completed if you, your spouse/domestic partner or one of your eligible dependents has other health insurance coverage or is eligible for Medicare. Please complete all information requested. Refer to your Medicare card to complete the Medicare Information section.

21) Should be completed by your Account Administrator.

22) You must sign and date the form where indicated.

Once the form is completed, retain the last copy for your records.

HIGHMARK BLUE CROSS BLUE SHIELD ENROLLMENT APPLICATION

Employee must complete items 1 through 13 and sign.

HIGHMARK® Blue Cross Blue Shield

Membership Department
P.O. Box 535193
Pittsburgh, PA 15253-5193

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYEE INFORMATION

1) Employer Name

Reason for Application: ❑ Enrollment ❑ New Hire ❑ Rehire ❑ COBRA ❑ Act 4 ❑ Other:

2) Employee First Name / Middle Initial / Last Name

3) Street Address | **4)** City | **5)** State | **6)** Zip

7) Social Security Number | **8)** Effective Date of Coverage: Month / Day / Year | **9)** Employee Status: ❑ Active ❑ Retired (Date) ______ ❑ Hourly ❑ Salary

10) Employee Phone #—Home ( ) | **11)** Employee Phone #—Work ( ) | **12)** Employee Hire Date: Month / Day / Year

13) Check Type of Coverage

	MEDICAL	VISION	DRUG	PRODUCT NAME
Employee Only	❑	❑	❑	❑
Insured & Spouse/Domestic Partner	❑	❑	❑	❑
Family	❑	❑	❑	❑
Parent & Child	❑	❑	❑	❑
Parent & Children	❑	❑	❑	❑

14) To be completed by Account Administrator only

Group Number	Report Code Qualifier	Report Code Value

Complete items 15 through 19 where applicable. List eligible participants. (If you have additional dependents, attach separate sheet.)

	Complete Where Applicable	First Name / Middle Initial / Last Name	Social Security Number	Do you have other insurance?	Birth Date Mo	Birth Date Dy	Birth Date Yr	Sex F/M	Check If Student Over 19	Check If Dis-abled	Check If Act 4
15)	Self			❑ Yes ❑ No If YES, then complete #20							
16)	❑ Spouse ❑ Dom. Part.*			❑ Yes ❑ No If YES, then complete #20							
17)	❑ Child ❑ Other*			❑ Yes ❑ No If YES, then complete #20							
18)	❑ Child ❑ Other*			❑ Yes ❑ No If YES, then complete #20							
19)	❑ Child ❑ Other*			❑ Yes ❑ No If YES, then complete #20							

***If "domestic partner" or "other" applies, complete using one of the following codes: (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter, (29) Domestic Partner**

20) If you checked YES to other insurance, fill in appropriate line:

Name of Insurance Carrier: ______

Group No: ______ Effective Date: ______

Name of Policy Holder: ______

Policy Number: ______

Relationship to Highmark Policy Holder: ______

Policy Holder Date of Birth: ______

Policy Holder Employment Status: ❑ Active ❑ Retired (Date) ______

MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits:

Name of Member Last	First	Health Insurance Claim Number	Part A Effective Date (Mo-Day-Yr)	Part B Effective Date (Mo-Day-Yr)	Part D Effective Date (Mo-Day-Yr)
			/ /	/ /	/ /
			/ /	/ /	/ /
			/ /	/ /	/ /

Why are you eligible for Medicare? ❑ Age ❑ Disability ❑ End Stage Renal Disease

Do you have a Medicare Supplement or other coverage that complements Medicare? ❑ Yes ❑ No

To the best of my knowledge and belief, the information provided on this application is true and correct. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that this form enrolls those eligible persons listed above in the Medical Plan as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

21) ______ Authorized Employer Signature ______ Date

22) ______ Employee Signature ______ Date

MARGINAL WORDS