Summary of Platinum EX Plus *Benefits*

On the chart below, you'll see what you pay for specific services. You are responsible for paying for non-emergency services received from an out-of-network provider. 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	In-Network	Out-of-Network
General Provisions		
Benefit Period	Plan Year	
Provider Network	WNY HMO/POS 200 Network locally; WNY PPO Network nationally	
Deductible Individual Family	 $0 $0	 $10,000 $20,000
Coinsurance	Covered in full	50% Coinsurance
Out-of-Pocket Maximum Individual Family	 $5,000 $10,000	 $20,000 $40,000
Deductible & Out-of-Pocket Max Administration	Embedded	
Domestic Partner and Children	Includes coverage for Domestic Partner and Children	
Office Visits		
Primary Care Provider Office & Telehealth Visits	$10 Copayment	50% Coinsurance
Specialist Office & Telehealth Visits	$30 Copayment	50% Coinsurance
Telemedicine (Well360 Virtual Health)	Covered in full	Not covered
Allergy Testing & Injections	$10 Copayment for PCP / $30 Copayment for Specialist	50% Coinsurance
Prenatal and Postnatal Care Cost-share applies to initial visit only	$10 Copayment	50% Coinsurance
Preventive Care		
Immunizations	Covered in full	50% Coinsurance
Colorectal cancer screening	Covered in full	50% Coinsurance
Mammograms	Covered in full	50% Coinsurance
Routine Physical exams	Covered in full	Not covered
Routine Gynecological exams	Covered in full	50% Coinsurance
Routine Diagnostic services	Covered in full	50% Coinsurance
Well Child Visits	Covered in full	50% Coinsurance
Hospital Services		
Inpatient Hospital	$500 Copayment	50% Coinsurance
Inpatient Maternity	$500 Copayment	50% Coinsurance
Outpatient Surgery Facility	$250 Copayment	50% Coinsurance
Skilled Nursing Facility	$500 Copayment	50% Coinsurance
Emergency & Urgent Care Services		
Emergency Room	$250 Copayment (waived if admitted)	
Ambulance	$250 Copayment	
Urgent Care Center	$100 Copayment	
Therapy, Rehabilitative and Habilitative Services		
Chiropractic Care	$10 Copayment	50% Coinsurance
Physical, Occupational, & Speech Therapies Rehabilitative and Habilitative	$10 Copayment	50% Coinsurance
	Benefit Limit: 60 combined PT/OT/ST Visits per condition per plan year	

Benefit	In-Network	Out-of-Network
Respiratory Therapy	$10 Copayment	50% Coinsurance
Mental Health & Substance Use Addictive Disorder		
Inpatient Mental Health	$500 Copayment	50% Coinsurance
Inpatient Substance Abuse Detoxification & Rehabilitation	$500 Copayment	50% Coinsurance
Outpatient Mental Health	Covered in full	50% Coinsurance
Outpatient Substance Abuse Detoxification & Rehabilitation	Covered in full	50% Coinsurance
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	$60 Copayment	50% Coinsurance
Radiology (X-ray, Diagnostic testing)	$30 Copayment	50% Coinsurance
Laboratory Testing & Pathology	$15 Copayment	50% Coinsurance
Other Services		
Diabetic Drugs, Equipment, & Supplies Includes Test strips, Syringes, etc	$10 Copayment	50% Coinsurance
Dialysis	$30 Copayment	50% Coinsurance
Chemotherapy	$10 Copayment for PCP / $30 Copayment for Specialist	50% Coinsurance
Durable Medical Equipment	50% Coinsurance	50% Coinsurance
Orthotics & Prosthetics	50% Coinsurance	50% Coinsurance
Home Health Care	$10 Copayment for PCP / $30 Copayment for Specialist	50% Coinsurance
	Benefit Limit: 40 visits per plan year Aggregate of Visiting Nurse, Home Infusion, and Home Health	
Hospice	$30 Copayment	50% Coinsurance
Wellness Card	$250 per contract for use at participating providers for exercise centers, fitness clubs, & gyms.	
Prescription Drugs		
Prescription Drug	**Retail Drugs (30-day Supply)** $5 Copayment $30 Copayment 50% Coinsurance **Mail Order Drugs (90-day Supply)** $12.50 Copayment $75 Copayment 42% Coinsurance	
Pediatric Vision Services - Davis Vision National Network		
Exam	Covered in full	Not Covered
Pediatric frame selection	Covered in full	Not Covered
Standard eyeglass lenses (per pair)	Covered in full	Not Covered
Pediatric Dental Services - United Concordia Elite Prime Network		
Preventive Services	$25 Copayment	Not Covered
Basic Services	50% Coinsurance	Not Covered
Major Services	50% Coinsurance	Not Covered
Medically Necessary Orthodontics	50% Coinsurance	Not Covered

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.

1) 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) Telemedicine Services must be performed by the Highmark Blue Cross Blue Shield Designated Telemedicine Vendor.

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) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved 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 SensibleRx Complete, when you purchase certain brand drugs that have generic equivalents, you will be responsible for the brand drug member cost share indicated plus the difference in cost between the brand and generic drugs. Your plan requires that you use a specific specialty pharmacy for hemophilia medications. Please contact member services for more details. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary.

Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- 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/Insurer 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.

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).

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

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).

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).

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).

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).

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

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).

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.

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.

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