Summary of PPO *Benefits*

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period.

Benefit	In-Network	Out-of-Network
Benefit Period①	Calendar Year	
Deductible (per benefit period) Individual Family	 $300 $600	 $600 $1,200
Plan Payment Level – Based on the provider's reasonable charge (PRC)	80% after deductible until out-of-pocket limit is met, then 100%	60% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limit (per benefit period)④ Individual Family	 $2,500 $5,000	 $5,000 $10,000
Total Maximum Out-of-Pocket⑤ (per benefit period) Individual Family	 $8,700 $17,400	 N/A N/A
Lifetime Maximum (per person)	Unlimited	Unlimited
Physician Office Visits	100% after $20 copayment	60% after deductible
Specialist Office Visits	100% after $20 copayment	60% after deductible
Urgent Care Center Visits	100% after $20 copayment	60% after deductible
Telemedicine Services⑨	100% after $0 copayment	Not Covered
Preventive Care⑦ ***Adult*** Routine Physical exams	 100% (deductible/copayment does not apply)	 Not Covered
Adult Immunizations	100% (deductible does not apply)	60% after deductible
Routine gynecological exams, including a PAP Test	100% (deductible/copayment does not apply)	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	60% after deductible
Well-Women Care⑧	100% (deductible does not apply)	60% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	60% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Pediatric Routine physical exams	 100% (deductible/copayment does not apply)	 Not Covered
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Emergency Room Services	100% after $50 copayment (waived if admitted)	
Spinal Manipulations	100% after $20 copayment	60% after deductible Limit: 25 visits/calendar year
Physical Medicine	100% after $20 copayment	60% after deductible
Speech Therapy	100% after $20 copayment	60% after deductible
Occupational Therapy	100% after $20 copayment	60% after deductible
Allergy Extracts and Injections	80% after deductible	60% after deductible
Ambulance	80% after deductible	
Applied Behavior Analysis for Autism Spectrum Disorders (ASD)⑥	80% after deductible	60% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diabetes Treatment	80% after deductible	60% after deductible
Diagnostic Services ***Advanced Imaging*** (MRI, CAT Scan, PET scan, etc.)	80% after deductible	60% after deductible

Benefit	In-Network	Out-of-Network
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	
Enteral Foods	80% (deductible does not apply)	60% (deductible does not apply)
Home Infusion Therapy	80% after deductible	
Home Health Care	80% after deductible	
Hospice	80% after deductible	
Hospital Services – Inpatient	80% after deductible	60% after deductible
Hospital Services – Outpatient	80% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment②	80% after deductible	60% after deductible
Maternity (facility & professional services)	80% after deductible	60% after deductible
Medical/Surgical Expenses (Except Office Visits)	80% after deductible	60% after deductible
Mental Health – Inpatient	80% after deductible	60% after deductible
Mental Health – Outpatient	80% after deductible	60% after deductible
Pediatric Extended Care Services	80% after deductible	60% after deductible
	Limit: 100 days/calendar year	
Private Duty Nursing	80% after deductible	
Respiratory Therapy	80% after deductible	
Skilled Nursing Facility Care	80% after deductible	
Substance Abuse – Inpatient Detoxification	80% after deductible	60% after deductible
Substance Abuse – Inpatient Rehabilitation	80% after deductible	60% after deductible
Substance Abuse – Outpatient	80% after deductible	60% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
Transplant Services	80% after deductible	60% after deductible
Precertification Requirements	Performed by Member③	

For Providers in your area call 1-800-810-BLUE

① Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

② Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy is covered.

③ Highmark Healthcare Management (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. 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.

④ Out-of-pocket limits do not include copayments, deductibles, prescription drug cost share, or amounts in excess of the Allowable Charge. Once the out-of-pocket limit is met, the plan will pay 100% for the remainder of the benefit period for benefits subject to coinsurance.

⑤ Total maximum out-of-pocket includes copayments, deductibles, prescription drug cost share and out-of-pocket limits. Once the total maximum out-of-pocket is met, the plan will pay 100% for the remainder of the benefit period. This amount is subject to change per ACA guidelines.

⑥ Coverage for eligible members to age 21. Services will be paid according to the benefit category, i.e., speech therapy. Treatment for autism spectrum disorders does not reduce visit/day limits.

⑦ Services are limited to those listed on the Highmark Preventive Schedule and the Women's Health Preventive Schedule. Gender, age and frequency limits may apply.

⑧ Benefits are provided for female members for items and services, including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods (In-Network coverage only) and counseling and breastfeeding support and counseling.

⑨ 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.

<table>
<tr><th>Benefit</th><th colspan="2">In-Network</th><th>Out-of-Network</th></tr>
<tr><td rowspan="2">National Plus Prescription Drug Program
(Defined by National Plus Pharmacy Network - Not Physician Network)</td><td colspan="2">Retail – 34-day supply
Mail Order – 90 day supply
Mandatory Generic①</td><td rowspan="2">Not Covered</td></tr>
<tr><td>Retail
➢ 25% copayment up to a maximum copayment of $200 per prescription</td><td>Mail-Order
➢ 20% copayment up to a maximum copayment of $200 per prescription</td></tr>
</table>

① The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand drug. The member payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or coinsurance amounts, which may apply.

American Red Cross Dental Plan

Benefit Provision	ConcordiaFlex
Diagnostic Services (Not subject to Annual Maximum) ➢ Routine oral examinations ➢ Dental X-rays - Full mouth X-rays - Bitewing X-rays	**100%**
Preventive Services (Not subject to Annual Maximum) ➢ Routine cleanings ➢ Topical fluoride application for dependent children under age 19 ➢ Space maintainers (not made of precious metals) that replace prematurely lost teeth for dependent children under 19 years of age ➢ Sealants when provided to children. Coverage is limited to one sealant per tooth in any three-year period	**100%**
Basic Restorative ➢ Fillings ➢ Simple extractions ➢ Endodontics, including pulpotomy and root canal treatment	**100%**
Periodontal Services ➢ Diagnosis and treatment planning including periodontal examination ➢ Non-surgical periodontal therapy including periodontal scaling and root planing ➢ Surgical periodontal therapy ➢ Maintenance – post treatment preventive periodontal procedures (periodontal cleanings)	**100%**
Oral Surgery ➢ Surgical removal of teeth	**100%**
Prosthetics ➢ Initial insertion of bridges (including pontics and abutment crowns, inlays and onlays) ➢ Initial insertion of partial or full dentures (including any adjustments during the six-month period following insertion) ➢ Replacement of an existing partial or full denture or bridge by a new denture or bridge	**80%**
Crown, Inlay and Onlay Restorations ➢ Single unconnected crowns, inlays and onlays ➢ Replacement of crowns, inlays and onlays, but only if satisfactory evidence is presented that at least 5 years have elapsed since the date of insertion of the existing crown, inlay or onlay, and only if the existing crown, inlay or onlay is unserviceable and cannot be made serviceable	**80%**
Orthodontics (Not subject to Annual Maximum) ➢ Diagnosis, including radiographs ➢ Active treatment, including necessary appliances ➢ Retention treatment following active treatment ➢ Lifetime maximum $2,500	**100%**
Annual Maximum	**$2,500**
Annual Deductible (*Excludes* Diagnostic, Preventive and Orthodontic Services)	**NONE**
Network	**ElitePLUS**
Out-of-Network Reimbursement	**90th Percentile**

NOTE: UCCI Participating Dentists will accept the Maximum Allowable Charge (MAC) reimbursement as payment in full.
This summary is intended as a general description of coverage. Specific limitations and exclusions may apply to some services.

Annual Plan Option

In-network benefits	Vision plan design
	Annual Plan
Frequency – once every:	**All members**
Eye health examination inclusive of dilation (when professionally indicated)	12 months
Spectacle lenses	12 months
Frame	12 months
Contact lenses (in lieu of eyeglasses)	12 months
Copayments	
Eye health examination	Covered
Contact lens evaluation and fitting	Covered
Eyeglass benefit - frame	
Frame allowance (retail):	Up to $130 OR Up to $180 at Visionworks[1] Plus a 20% discount on any overage
Davis vision frame collection[2] (in lieu of allowance):	
Fashion level	Covered
Designer level	Covered
Premier level	$25 member charge
Eyeglass benefit – Spectacle Lenses	
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	Covered
Tinting of plastic lenses	Covered
Scratch-resistant coating	Covered
Polycarbonate lenses (children[3] / adults)	$0 / $30
Ultraviolet coating	$12
Anti-reflective (AR) coating (Standard / premium / ultra)	$35 / $48 / $60
Progressive lenses (standard / premium / ultra)	$50 / $90 / $140
High-index lenses	$55
Polarized lenses	$75
Photochromic lenses (glass / plastic)	$20 / $65
Intermediate-vision lenses	$30
Blended-segment lenses	$20
Scratch protection plan: single vision / multifocal lenses	$20 / $40
Contact lens benefit (in lieu of eyeglasses)	
Contact lens: materials allowance	Up to $130 plus 15% discount on any overage
- Evaluation, fitting & follow-up care – standard & specialty lens types	15% Discount
Exclusive Collection contact lenses[2] (in lieu of allowance): Materials: disposable or planned replacement: up to	4 or 2 boxes
- Evaluation, fitting & follow-up care	Covered
Visually required contact lenses (with prior approval) - Materials, evaluation, fitting & follow-up care	Covered
Additional savings	
Retinal imaging – member charge	$39
Additional pairs of eyeglasses	30% Discount

Out-of-network reimbursement schedule			
Eye examination: $40	Single vision lenses: $40	Trifocal lenses: $80	Elective contact lenses: $105
Frame: $50	Bifocal/progressive lenses: $60	Lenticular lenses: $100	Visually required CL: $225

[1]Enhanced frame allowance is available at all Visionworks locations nationwide.

[2]Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.

[3]Polycarbonate lenses are covered for dependent children, monocular patients, and patients with prescriptions +/- 6.00 diopters or greater.

One-year eyeglass breakage warranty included