Shadowfax Corporation 2021 Choice Blue $500

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	In-Network Enhanced Value	In-Network Standard Value	Out of Network
General Provisions			
Effective Date	March 1, 2021		
Benefit Period (1)	Contract Year		
Deductible (per benefit period) (All in-network services are credited to both enhanced and standard deductibles.) Individual Family	 $500 $1,000	 $1,500 $3,000	 $3,000 $6,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible	60% after deductible
Out-of-Pocket Limit (Includes coinsurance. 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 Family	 None None	 $1,250 $2,500	 $2,500 $5,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays 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	 $6,850 $13,700		 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after $15 copay	100% after $30 copay	60% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $15 copay	100% after $30 copay	60% after deductible
Specialist Office Visits & Virtual Visits	100% after $30 copay	100% after $60 copay	60% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible	60% after deductible
Urgent Care Center Visits	100% after $30 copay	100% after $60 copay	60% after deductible
Telemedicine Services (3)	100% after $10 copay		not covered
Preventive Care (4)			
Routine Adult Physical Exams	100% (deductible does not apply)	100% (deductible does not apply)	60% after deductible
Adult Immunizations	100% (deductible does not apply)	100% (deductible does not apply)	60% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	100% (deductible does not apply)	60% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	100% (deductible does not apply)	60% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	100% (deductible does not apply)	60% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	100% (deductible does not apply)	60% after deductible
Routine Pediatric Physical Exams	100% (deductible does not apply)	100% (deductible does not apply)	60% after deductible
Pediatric Immunizations	100% (deductible does not apply)	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	100% (deductible does not apply)	60% after deductible

Emergency Services			
Emergency Room Services	100% after $250 copay (waived if admitted)		
Ambulance - Emergency	100% after deductible	100% after enhanced in-network deductible	100% after enhanced in-network deductible
Ambulance - Non-Emergency	100% after deductible	100% after enhanced in-network deductible	60% after program deductible
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	100% after deductible	80% after deductible	60% after deductible
Hospital Outpatient	100% after deductible	80% after deductible	60% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible	60% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	80% after deductible	60% after deductible
Therapy and Rehabilitation Services			
Physical Medicine	100% after $30 copay	100% after $60 copay	60% after deductible
	limit: 20 visits/benefit period		
Respiratory Therapy	100% after deductible	80% after deductible	60% after deductible
Speech Therapy	100% after $30 copay	100% after $60 copay	60% after deductible
	limit: 12 visits/benefit period		
Occupational Therapy	100% after $30 copay	100% after $60 copay	60% after deductible
	limit: 12 visits/benefit period		
Spinal Manipulations	100% after $30 copay	100% after $60 copay	60% after deductible
	limit: 20 visits/benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible	60% after deductible
Mental Health / Substance Abuse			
Inpatient Mental Health Services	100% after deductible	100% after enhanced in-network deductible	60% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	100% after enhanced in-network deductible	60% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after deductible		60% after deductible
Outpatient Substance Abuse Services	100% after deductible		60% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	80% after deductible	60% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (5)	100% after deductible	80% after deductible	60% 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	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible	60% after deductible
Home Health Care	100% after deductible	80% after deductible	60% after deductible
	limit: 90 visits/benefit period aggregate with visiting nurse		
Hospice	100% after deductible	100% after enhanced in-network deductible	60% after deductible
Infertility Counseling, Testing and Treatment (6)	100% after deductible	80% after deductible	60% after deductible
Private Duty Nursing	100% after deductible	80% after deductible	60% after deductible
	limit: 240 hours/benefit period		
Skilled Nursing Facility Care	100% after deductible	80% after deductible	60% after deductible
	limit: 100 days/benefit period		
Transplant Services	100% after deductible	100% after enhanced in-network deductible	60% after deductible
Precertification Requirements (7)	Yes	Yes	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 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 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.

HIGHMARK.

An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Plan 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 Plan 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 Plan 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 Plan 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 Plan:

- 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 Plan 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.

If you speak English, language assistance services, free of charge, are available to you. Call 1-888-269-8412.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-888-269-8412.

如果您说中文，可向您提供免费语言协助服务。
請致電 1-888-269-8412.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-888-269-8412.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-888-269-8412.

Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du 1-888-269-8412 uffrufe.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다.
1-888-269-8412 로 전화.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-888-269-8412.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-888-269-8412 .

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-888-269-8412.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-888-269-8412.

જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-888-269-8412 નંબર પર ફોન કરો.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-888-269-8412.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-888-269-8412.

បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ការហៅ 1-888-269-8412 ។

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-888-269-8412.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-888-269-8412.

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。 1-888-269-8412 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان
با تماس با شماره 1-888-269-8412 .

Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-888-269-8412.