HIGHMARK.
Performance Flex Blue PPO

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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.

Group Numbers: 10927377-97

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
General Provisions			
Effective Date	January 1, 2026		
Benefit Period(1)	Calendar		
Deductible (per benefit period) (All in-network services are credited to both the enhanced and the standard deductibles.)			
Individual	$250	$500	$1,000
Family	$500	$1,000	$2,000
Plan Pays – payment based on the plan allowance	100%	90% after deductible	75% 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 enhanced and the standard out-of-pocket limits.)			
Individual	None	$1,500	$3,000
Family	None	$3,000	$6,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copay, 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	$9,100		Not Applicable
Family	$18,200		Not Applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	100% after $15 copayment	100% after $20 copayment	75% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $15 copayment	100% after $20 copayment	75% after deductible
Specialist Office Visits & Virtual Visits	100% after $30 copayment	100% after $30 copayment	75% after deductible
Virtual Visit Provider Originating Site Fee	100%	90% after deductible	75% after deductible
Urgent Care Center Visits	100% after $15 copayment	100% after $20 copayment	75% after deductible
Telemedicine Services (3)	100% after $8 copayment		Not Covered
Preventive Care(4)			
Routine Adult			
Physical exams	100% (deductible does not apply)		75% after deductible
Adult immunizations	100% (deductible does not apply)		75% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)		75% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)		75% after deductible
Diagnostic services and procedures	100% (deductible does not apply)		75% after deductible
Routine Pediatric			
Physical exams	100% (deductible does not apply)		75% after deductible
Pediatric immunizations	100% (deductible does not apply)		75% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)		75% after deductible
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Inpatient	100%	90% after deductible	75% after deductible
Hospital Outpatient	100%	90% after deductible	75% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100%	90% after deductible	75% after deductible
Medical Care (including inpatient visits and consultations)/ **Surgical Expenses**	100%	90% after deductible	75% after deductible
Emergency Services			
Emergency Room Services (5)	100% after $75 copayment (waived if admitted)		
Ambulance – Emergency (6)	100%		
Ambulance – Non-Emergency (6)	100%		

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Therapy and Rehabilitation Services			
Physical Medicine	100%	100% after $30 copayment	75% after deductible
Respiratory Therapy	100%	90% after deductible	75% after deductible
Speech Therapy	100%	100% after $30 copayment	75% after deductible
Occupational Therapy	100%	100% after $30 copayment	75% after deductible
Spinal Manipulations	100% after $20 copayment	100% after $30 copayment	75% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	90% after deductible	75% after deductible
Mental Health/Substance Abuse			
Inpatient Mental Health Services	100%		75% after deductible
Inpatient Detoxification/Rehabilitation	100%		75% after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	100%		75% after deductible
Outpatient Substance Abuse Services	100%		75% after deductible
Other Services			
Allergy Extracts and Injections	100%	90% after deductible	75% after deductible
Assisted Fertilization Procedures	100% after 50% of the cost of Covered Services up to $200 per member per benefit period.		Not Covered
Dental Services Related to Accidental Injury	100%	90% after deductible	Not Covered
Diagnostic Services			
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	90% after deductible	75% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	90% after deductible	75% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	90% after deductible	75% after deductible
Home Health Care	100%	90% after deductible	75% after deductible
Hospice	100%	90% after deductible	75% after deductible
Infertility Counseling, Testing and Treatment(7)	100%	90% after deductible	75% after deductible
Private Duty Nursing	100%	90% after deductible	75% after deductible
Skilled Nursing Facility Care	100%	90% after deductible	75% after deductible
Transplant Services (8)	100%	90% after deductible	75% after deductible
Precertification Requirements(9)	Yes		
Prescription Drugs			
Prescription Drug Deductible			
Individual	None		
Family	None		
Prescription Drug Program(10) SensibleRx Complete *Defined by the National Plus 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 (34 day supply)** $15 Generic copayment $25 Formulary Brand copayment $45 Non-Formulary Brand copayment **Retail Drugs (90 day supply)** $45 Generic copayment $75 Formulary Brand copayment $135 Non-formulary Brand copayment **Maintenance Drugs through Mail Order (90 day Supply)** $15 Generic copayment $25 Formulary Brand copayment $45 Non-Formulary Brand copayment		

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.

The terms "Enhanced Value" and "Standard Value" are not descriptors of the provider's ability.

Signature of Client Representative _____ Title _____ Date _____

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) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
5) 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.
6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.

7) 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. Covered services will be covered according to the benefit category to which they apply (e.g. outpatient surgery, hospital inpatient, diagnostic services).
8) Covered services will be covered according to the benefit category to which they apply (e.g. outpatient surgery, hospital inpatient, diagnostic services
9) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.
10) 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 SensibleRx Complete 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.

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company, or Highmark Choice Company.

Discrimination is Against the Law

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- 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 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: Civil RightsCoordinator@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.

Please note that your plan sponsor - and not the claims administrator- is entirely responsible for determining member eligibility and for the design of your plan/program.

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).

ATENCION: Si usted habla esparto', servicios de asistencia linguistica, de forma gratuita, estan disponibles pare usted. Llame al numero en la parte posterior de su tarjeta de identificacion (TTY: 711).

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ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti it numero riportato sul retro della sua carta d'identita (TTY: 711).

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ATTENTION: Si vous parlez franca's, les services d'assistance linguistique, gratuitement, sont a votre disposition. Appelez le numero au dos de votre carte d'identite (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstiitzung kostenlos zur Verffigung. Rufen Sie dazu die auf der ROckseite Ihres Versicherungsausweises (TTy: 711) aufgeffihrte Nummer an.

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Kominike : Si se Kreyol Ayisyen ou pale, gen sevis entepret, gratis-ticheri, ki la you ede w. Rele nan nimewo ki nan do kat idantite w la (ITY: 711).

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ATEKAO: Sea sua lingua é o portugues, temos atendimento gratuito para voce no seu idioma. Ligue para o numero no verso da sua Identidade (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).

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Aandacht: I ndien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (M:711).