CENTRAL PENNSYLVANIA REGION

# PEDIATRIC DENTAL AND VISION COVERAGE BENEFIT SUMMARY

FOR SMALL GROUPS

Effective January 1, 2023

**HIGHMARK BLUE SHIELD AND HIGHMARK BENEFITS GROUP CENTRAL PENNSYLVANIA REGION:**
**SMALL GROUP ACA – 50 OR FEWER EMPLOYEES**

# 2023 Pediatric Vision Coverage Benefit Summary

| NETWORK BENEFIT (Independents & Visionworks)* | Frequency – once every: | Child Pediatric – Members under 19 years of age[1] |
|---|---|---|
| Eye examination inclusive of dilation (when professionally indicated) | 12 Months | $0 copay |
| Spectacle lenses** | 12 Months | $0 copay |
| Frames** | 12 Months | $0 copay |
| Contact lens evaluation, fitting & follow-up care (in lieu of eyeglasses)** | 12 Months | $0 copay |
| Contact lenses (in lieu of eyeglasses)** | 12 Months | $0 copay |
| **Eyeglass benefit – frame** | | |
| **Frame allowance (retail):** | Up to $150<br>Plus a 20% discount on any overage | |
| Davis Vision Exclusive Collection (in lieu of allowance): | | |
| Fashion / Designer / Premier - member charge (if applicable) | $0 / $0 / $0 | |
| **Eyeglass benefit – spectacle lenses** | | |
| Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx) | $0 | |
| Digital single vision (intermediate) | $30 | |
| Tinting of plastic lenses (solid / gradient) | $11 | |
| Scratch-resistant coating | $0 | |
| Polycarbonate lenses (children / adults) | $0 | |
| Ultraviolet coating | $12 | |
| Blue-light filtering | $15 | |
| Anti-reflective (AR) coating (standard / premium / ultra / ultimate) | $35 / $48 / $60 / $85 | |
| Progressive lenses[3] (standard / premium / ultra / ultimate) | $50 / $90 / $140 / $175 | |
| High-index lenses (thinner and lighter) | $55 / $120 | |
| Polarized lenses | $75 | |
| Plastic photochromic lenses | $65 | |
| Scratch protection plan: single vision / multifocal lenses | $20 / $40 | |
| **Contact lens benefit (in lieu of eyeglasses)** | | |
| **Contact lens: materials allowance** | Up to $150<br>Plus a 15% discount on any overage | |
| Evaluation, fitting, and follow-up care – standard and specialty lens types | Not Covered | |
| Evaluation, fitting, and follow-up care – standard lens types | Not Covered | |
| **Exclusive Collection contact lenses[4] (in lieu of allowance):** | | |
| Materials: disposable or planned replacement: | Up to 4 or 2 boxes | |
| Evaluation, fitting, and follow-up care | $0 | |
| **Visually required contact lenses** (with prior approval) - Materials, evaluation, fitting, and follow-up care | $0 with prior approval | |

**These benefits apply to Qualified High-Deductible Health Plans (QHDHP).**

(1) Dependents will be terminated from vision coverage at the end of the month in which they turn 19.
(2) Includes glass, plastic, or oversized lenses.
(3) Progressive multifocals can be worn by most people. Conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive lenses. However, the member's payment toward the progressive upgrade will not be refunded.
(4) Disposable contact lens wearers will receive four multipacks of lenses. Planned replacement lens wearers will receive two multipacks of lenses.
* Vision benefits utilize the Davis Vision Network. There is no out-of-network coverage. Davis Vision is a separate company that administers Highmark vision benefits. Visionworks, also a separate company, is a provider within the Davis Vision Network.
** Subject to deductible.

**HIGHMARK BLUE SHIELD AND HIGHMARK BENEFITS GROUP CENTRAL PENNSYLVANIA REGION:**
**SMALL GROUP ACA – 50 OR FEWER EMPLOYEES**

# 2023 Pediatric Vision Coverage Benefit Summary

| NETWORK BENEFIT (Independents & Visionworks)* | Frequency – once every: | Child Pediatric – Members under 19 years of age[1] |
|---|---|---|
| Eye examination inclusive of dilation (when professionally indicated) | 12 Months | $0 copay |
| Spectacle lenses | 12 Months | $0 copay |
| Frames | 12 Months | $0 copay |
| Contact lens evaluation, fitting and follow-up care (in lieu of eyeglasses) | 12 Months | $0 copay |
| Contact lenses (in lieu of eyeglasses) | 12 Months | $0 copay |
| **Eyeglass benefit – frame** | | |
| **Frame allowance (retail):** | Up to $150<br>Plus a 20% discount on any overage | |
| Davis Vision Exclusive Collection (in lieu of allowance): | | |
| Fashion / Designer / Premier - member charge (if applicable) | $0 / $0 / $0 | |
| **Eyeglass benefit – spectacle lenses** | | |
| Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx) | $0 | |
| Digital single vision (intermediate) | $30 | |
| Tinting of plastic lenses (solid / gradient) | $11 | |
| Scratch-resistant coating | $0 | |
| Polycarbonate lenses (children / adults) | $0 | |
| Ultraviolet coating | $12 | |
| Blue-light filtering | $15 | |
| Anti-reflective (AR) coating (standard / premium / ultra / ultimate) | $35 / $48 / $60 / $85 | |
| Progressive lenses[3] (standard / premium / ultra / ultimate) | $50 / $90 / $140 / $175 | |
| High-index lenses (thinner and lighter) | $55 / $120 | |
| Polarized lenses | $75 | |
| Plastic photochromic lenses | $65 | |
| Scratch protection plan: single vision / multifocal lenses | $20 / $40 | |
| **Contact lens benefit (in lieu of eyeglasses)** | | |
| **Contact lens: materials allowance** | Up to $150<br>Plus a 15% discount on any overage | |
| Evaluation, fitting, and follow-up care – standard and specialty lens types | Not Covered | |
| Evaluation, fitting, and follow-up care – standard lens types | Not Covered | |
| **Exclusive Collection contact lenses[4] (in lieu of allowance):** | | |
| Materials: disposable or planned replacement: | Up to 4 or 2 boxes | |
| Evaluation, fitting, and follow-up care | $0 | |
| **Visually required contact lenses** (with prior approval) - Materials, evaluation, fitting, and follow-up care | $0 with prior approval | |

**These benefits apply to all plans other than Qualified High-Deductible Health Plans (QHDHP).**

(1) Dependents will be terminated from vision coverage at the end of the month in which they turn 19.
(2) Includes glass, plastic, or oversized lenses.
(3) Progressive multifocals can be worn by most people. Conventional bifocals will be supplied at no additional charge for anyone who is unable to adapt to progressive lenses. However, the member's payment toward the progressive upgrade will not be refunded.
(4) Disposable contact lens wearers will receive four multipacks of lenses. Planned replacement lens wearers will receive two multipacks of lenses.
* Vision benefits utilize the Davis Vision Network. There is no out-of-network coverage. Davis Vision is a separate company that administers Highmark vision benefits. Visionworks, also a separate company, is a provider within the Davis Vision Network.

**HIGHMARK BLUE SHIELD AND HIGHMARK BENEFITS GROUP**
**CENTRAL PENNSYLVANIA REGION:**
**SMALL GROUP ACA – 50 OR FEWER EMPLOYEES**

# 2023 Pediatric Dental Coverage Benefit Summary

**These benefits apply to Qualified High-Deductible Health Plans (QHDHP).**

This plan meets the minimum essential health benefit requirements for pediatric oral health as required under the Federal Affordable Care Act.

These benefits are only available for children through the end of the benefit period that they turn 19.

This plan will pay benefits for covered services shown below subject to exclusions and other policy terms. Payment is based on the plan allowance for the specific covered service. Participating dentists accept contracted plan allowance as payment in full for services.

**Contract Year Deductible per member:**
Combined with Medical

**Annual Maximum per member:**
Unlimited

**Out-of-Pocket (OOP) Year Maximum per member:**
Combined with Medical

| SERVICE CATEGORY | WAITING PERIOD | POLICY PAYS IN-NETWORK DENTISTS* | POLICY PAYS OUT-OF-NETWORK DENTISTS | AFTER DEDUCTIBLE |
|---|---|---|---|---|
| Oral Evaluations (Exams) | None | 100% | Not Covered | No |
| Radiographs (All X-rays) | None | 100% | Not Covered | No |
| Prophylaxis (Cleanings) | None | 100% | Not Covered | No |
| Fluoride Treatments | None | 100% | Not Covered | No |
| Palliative Treatment (Emergency) | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Sealants | None | 100% | Not Covered | No |
| Space Maintainers | None | 100% | Not Covered | No |
| Basic Restoration Anterior Amalgam | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Basic Restoration Anterior Composite | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Basic Restoration Posterior Amalgam | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Crowns, Inlays, Onlays | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Crown Repair | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Endodontic Therapy (Root canals, etc.) | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Surgical Periodontics | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Non-Surgical Periodontics | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Periodontal Maintenance | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Prosthetics (Complete or Fixed Partial Dentures) | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Adjustments and Repairs of Prosthetics | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Maxillofacial Prosthetics | N/A | Not Covered | Not Covered | N/A |
| Implant Services | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Simple Extractions | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Surgical Extractions | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Oral Surgery | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| General Anesthesia, Nitrous Oxide, and/or IV Sedation | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Consultations | None | Coinsurance matches medical coinsurance | Not Covered | Yes |
| Medically Necessary Orthodontics | None | Coinsurance matches medical coinsurance | Not Covered | Yes |

*Pediatric Dental benefits utilize the United Concordia Advantage Provider Network. Members must use a United Concordia provider. There is no out-of-network coverage for this benefit. United Concordia Companies, Inc., is a separate company that administers pediatric dental benefits for Highmark Blue Shield members.

## Dentally Necessary Orthodontics Coverage

In this section, "Dentally Necessary" shall mean dental services determined by a Dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the Dentist and the prevailing standards of care in the professional community. The determination will be made by the Dentist in accordance with guidelines established by the Plan.

Orthodontic treatment limitations:

1. All pediatric orthodontic treatment is subject to Pre-certification by the Plan, and must be part of an approved written plan of care.
2. To be eligible for pediatric orthodontic treatment, a Member must
   a) continue to be enrolled during the duration of treatment; and
   b) have a fully erupted set of permanent teeth
3. Orthodontics Covered Services which are intended to treat a severe dentofacial abnormality and are the only method capable of preventing irreversible damage to the Member's teeth or their supporting structures, and restoring the Member's oral structure to health and function.

A Dentally Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality.

## Coverage of Dentally Necessary Orthodontics

1. Orthodontic treatment must be Dentally Necessary and be the only method capable of:
   a) preventing irreversible damage to the Insured member's teeth or their supporting structures and,
   b) restoring the Insured member's oral structure to health and function.
2. Insured members must have a fully erupted set of permanent teeth to be eligible for comprehensive, Dentally Necessary orthodontic services.
3. All Dentally Necessary orthodontic services require prior approval and a written plan of care.

**HIGHMARK BLUE SHIELD AND HIGHMARK BENEFITS GROUP CENTRAL PENNSYLVANIA REGION: SMALL GROUP ACA – 50 OR FEWER EMPLOYEES**

# 2023 Pediatric Dental Coverage Benefit Summary

This plan meets the minimum essential health benefit requirements for pediatric oral health as required under the Federal Affordable Care Act.

These benefits are only available for children through the end of the benefit period that they turn 19.

This plan will pay benefits for covered services shown below subject to exclusions and other policy terms. Payment is based on the plan allowance for the specific covered service. Participating dentists accept contracted plan allowance as payment in full for services.

**These benefits apply to all plans other than Qualified High-Deductible Health Plans.**

**Contract Year Deductible per member:**
$0

**Annual Maximum per member:**
Unlimited

**Out-of-Pocket (OOP) Year Maximum per member:**
Combined with Medical

| SERVICE CATEGORY | WAITING PERIOD | POLICY PAYS IN-NETWORK DENTISTS* | POLICY PAYS OUT-OF-NETWORK DENTISTS | AFTER DEDUCTIBLE |
|---|---|---|---|---|
| Oral Evaluations (Exams) | None | 100% | Not Covered | N/A |
| Radiographs (All X-rays) | None | 100% | Not Covered | N/A |
| Prophylaxis (Cleanings) | None | 100% | Not Covered | N/A |
| Fluoride Treatments | None | 100% | Not Covered | N/A |
| Palliative Treatment (Emergency) | None | 100% | Not Covered | N/A |
| Sealants | None | 100% | Not Covered | N/A |
| Space Maintainers | None | 100% | Not Covered | N/A |
| Basic Restoration Anterior Amalgam | None | 50% | Not Covered | N/A |
| Basic Restoration Anterior Composite | None | 50% | Not Covered | N/A |
| Basic Restoration Posterior Amalgam | None | 50% | Not Covered | N/A |
| Crowns, Inlays, Onlays | None | 50% | Not Covered | N/A |
| Crown Repair | None | 50% | Not Covered | N/A |
| Endodontic Therapy (Root canals, etc.) | None | 50% | Not Covered | N/A |
| Surgical Periodontics | None | 50% | Not Covered | N/A |
| Non-Surgical Periodontics | None | 50% | Not Covered | N/A |
| Periodontal Maintenance | None | 50% | Not Covered | N/A |
| Prosthetics (Complete or Fixed Partial Dentures) | None | 50% | Not Covered | N/A |
| Adjustments and Repairs of Prosthetics | None | 50% | Not Covered | N/A |
| Maxillofacial Prosthetics | N/A | Not Covered | Not Covered | N/A |
| Implant Services | None | 50% | Not Covered | N/A |
| Simple Extractions | None | 50% | Not Covered | N/A |
| Surgical Extractions | None | 50% | Not Covered | N/A |
| Oral Surgery | None | 50% | Not Covered | N/A |
| General Anesthesia, Nitrous Oxide, and/or IV Sedation | None | 50% | Not Covered | N/A |
| Consultations | None | 100% | Not Covered | N/A |
| Medically Necessary Orthodontics | None | 50% | Not Covered | N/A |

*Pediatric Dental benefits utilize the United Concordia Advantage Provider Network. Members must use a United Concordia provider. There is no out-of-network coverage for this benefit. United Concordia Companies, Inc., is a separate company that administers pediatric dental benefits for Highmark Blue Shield members.

## Dentally Necessary Orthodontics Coverage

In this section, "Dentally Necessary" shall mean dental services determined by a Dentist to either establish or maintain a patient's dental health based on the professional diagnostic judgment of the Dentist and the prevailing standards of care in the professional community. The determination will be made by the Dentist in accordance with guidelines established by the Plan.

Orthodontic treatment limitations:

1. All pediatric orthodontic treatment is subject to Pre-certification by the Plan, and must be part of an approved written plan of care.
2. To be eligible for pediatric orthodontic treatment, a Member must
   a) continue to be enrolled during the duration of treatment; and
   b) have a fully erupted set of permanent teeth
3. Orthodontics Covered Services which are intended to treat a severe dentofacial abnormality and are the only method capable of preventing irreversible damage to the Member's teeth or their supporting structures, and restoring the Member's oral structure to health and function.

A Dentally Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality.

## Coverage of Dentally Necessary Orthodontics

1. Orthodontic treatment must be Dentally Necessary and be the only method capable of:
   a) preventing irreversible damage to the Insured member's teeth or their supporting structures and,
   b) restoring the Insured member's oral structure to health and function.
2. Insured members must have a fully erupted set of permanent teeth to be eligible for comprehensive, Dentally Necessary orthodontic services.
3. All Dentally Necessary orthodontic services require prior approval and a written plan of care.

Health benefits or health benefit administration may be provided by or through Highmark Blue Shield, Highmark Benefits Group, or Highmark Health Insurance Company, all of which are independent licensees of the Blue Cross Blue Shield Association.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4108.

**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.

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.

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

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

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 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 se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-888-269-8412.

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

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 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.

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

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 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 .

HIGHMARK.