Southeastern Pennsylvania region

Pediatric dental and vision coverage benefit summary

for small groups

Effective January 1, 2025

HIGHMARK BLUE SHIELD AND HIGHMARK HEALTH INSURANCE COMPANY:
SMALL GROUP ACA — 50 OR FEWER EMPLOYEES

2025 pediatric vision coverage benefit summary

Network benefit (independents & Visionworks)*	Frequency	Child pediatric – members under 19 years of age[1]
Eye examination inclusive of dilation (when professionally indicated)	12 months	$0 copay
Spectacle lenses[2]**	12 months	$0 copay
Frames**	12 months	$0 copay
Contact lenses (in lieu of eyeglasses)**	12 months	$0 copay
Eyeglass benefit – frame[3]		
Davis Vision Exclusive Collection (in lieu of allowance) Fashion/Designer/Premier — member charge (if applicable):	$0/$0/$0	
Non-Collection frame allowance (retail)	Up to $150, plus a 20% discount on any overage	
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[4] (standard/premium/ultra/ultimate)	$50/$90/$140/$175	
High-index lenses (thinner and lighter)	$55/$120	
Polarized lenses	$75	
Plastic photosensitive lenses	$65	
Scratch protection plan: single vision/multifocal lenses	$20/$40	
Contact lens benefit (in lieu of eyeglasses)		
Contact lens materials allowance[3]	Up to $150, plus a 20% 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[3] (in lieu of allowance):		
Materials: disposable or planned replacement	Up to 4 or 2 boxes[5]	
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 high-deductible health plans (HDHP).

(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) Collection frames or contact lenses will be covered at 100%. If a non-collection frame or contact lense is selected, a $150 allowance will be applied. For any amount over $150 on a non-collection frame or contact lense, the member will be responsible for 20% of the cost of the overage.
(4) 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.
(5) 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.

View a list of network providers at: https://idoc.davisvision.com/members/Highmark/FindAProvider/Index

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Scratch protection plan: single vision/multifocal lenses	$20/$40	
Contact lens benefit (in lieu of eyeglasses)		
Contact lens materials allowance[3]	Up to $150, plus a 20% 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[3] (in lieu of allowance):		
Materials: disposable or planned replacement	Up to 4 or 2 boxes[5]	
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 non-high-deductible health plans (non-HDHP).

(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) Collection frames or contact lenses will be covered at 100%. If a non-collection frame or contact lense is selected, a $150 allowance will be applied. For any amount over $150 on a non-collection frame or contact lense, the member will be responsible for 20% of the cost of the overage.
(4) 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.
(5) 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.

View a list of network providers at: https://idoc.davisvision.com/members/Highmark/FindAProvider/Index

HIGHMARK BLUE SHIELD
AND HIGHMARK HEALTH INSURANCE COMPANY:
SMALL GROUP ACA — 50 OR FEWER EMPLOYEES

2025 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 qualified high-deductible health plans (QHDHP).

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 (after deductible)	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 (after deductible)	Not covered	Yes
Basic Restoration Anterior Composite	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
Basic Restoration Posterior Amalgam	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
Crowns, Inlays, Onlays	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
Crown Repair	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
Endodontic Therapy (Root canals, etc.)	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
Surgical Periodontics	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
Non-Surgical Periodontics	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
Occlusal Guard	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
Periodontal Maintenance	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
Prosthetics (Complete or Fixed Partial Dentures)	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
Adjustments and Repairs of Prosthetics	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes

*Pediatric Dental benefits utilize the United Concordia Advantage Plus 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 members.

Service category	Waiting period	Policy pays in-network dentists*	Policy pays out-of-network dentists	After deductible
Maxillofacial Prosthetics	N/A	Not covered	Not covered	N/A
Implant Services	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
Simple Extractions	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
Surgical Extractions	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
Oral Surgery	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
General Anesthesia and/or IV Sedation	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
Consultations	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes
Medically Necessary Orthodontics	None	Coinsurance matches medical coinsurance (after deductible)	Not covered	Yes

*Pediatric Dental benefits utilize the United Concordia Advantage Plus 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 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.

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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
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Implant Services	None	50%	Not covered	N/A
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Consultations	None	100%	Not covered	N/A
Medically Necessary Orthodontics	None	50%	Not covered	N/A

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United Concordia is a separate company that administers dental benefits.

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 Shield, Highmark Benefits Group Inc., or Highmark Health Insurance Company.

Your plan may not cover all your health care expenses. Read your plan materials carefully to determine which health care services are covered. For more information, call the number on the back of your member ID card or, if not a member, call 866-459-4418.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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, 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）。

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.

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

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).

אכטונג: אויב איר רעדט אידיש, זענען שפראך הילף סערוויסעס, פריי פון אפצאל, אוועילעבל פאר אייך. רופט די נומער וואס איז אויף די פארקערטע זייט פון אייער ID קארטל (TTY:711).

মনোযোগ দিন: আপনি যদি বাংলা ভাষায় কথা বলেন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ রয়েছে। আপনার আইডি কার্ডের পিছনে থাকা নম্বরে ফোন করুন। (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).

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

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (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).

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).

ΠΡΟΣΟΧΗ: Σε περίπτωση που μιλάτε Ελληνικά, οι διαθέσιμες υπηρεσίες γλωσσικής βοήθειας σας παρέχονται δωρεάν. Καλέστε τον αριθμό στο πίσω μέρος της ταυτότητας σας (TTY:711).

HIGHMARK