BLUEADVANTAGE® EPO HSA $1,350/$2,700 100

WITH A HEALTH SAVINGS ACCOUNT (HSA) OPTION AND INTEGRATED PRESCRIPTION DRUG BENEFIT

PLAN YEAR DEDUCTIBLES	
Individual	$1,350
Family	$2,700
Plan Year Coinsurance Limit:	Individual/Family None
PREVENTIVE MEDICAL SERVICES	**IN NETWORK BENEFITS**
Periodic Physical Exams	Covered at 100%
Routine Annual GYN Exam	Covered at 100%
Routine Mammogram	Covered at 100%
Routine Sigmoidoscopy & Colonoscopy	Covered at 100%
Routine Pap Smear	Covered at 100%
Routine Well-Child Care	Covered at 100%
Immunizations	Covered at 100%
Routine Vision Exams	Covered at 100%
Routine Hearing Exams	Covered at 100%
Prostate Screening Antigen Test	Covered at 100%
Lead Poisoning Screening Test	Covered at 100%
TREATMENT OF ILLNESS OR INJURY	**IN NETWORK BENEFITS**
Primary Doctor's Office Visits for Diagnosis & Treatment	Covered at 100%[1]
Specialist/Referral Care	Covered at 100%[1]
Laboratory Services – Independent – Hospital based	 Covered at 100%[1] Covered at 100%[1]
Imaging & Machine Testing Services – Independent – Hospital based	 Covered at 100%[1] Covered at 100%[1]
Outpatient High Tech Radiology Independent and Hospital Based (i.e. MRI, MRA, CT, CTA, PET scan)	Covered at 100%[1]
Chiropractic (up to 30 visits per Plan year)	Covered at 100%[1]
Physical & Occupational Therapy (30 visits combined per Plan year)	Covered at 100%[1]
Speech Therapy (30 visits per Plan Year)	Covered at 100%[1]
Radiation Therapy and Chemotherapy	Covered at 100%[1]
Inpatient Hospital – Semiprivate Room (including intensive care, if medically necessary) – Physician's & Surgeon's Services – Other Medical Professional Services	 Covered at 100%[1] Covered at 100%[1] Covered at 100%[1]
Maternity (hospital, birthing center and pre-natal and post-natal care)	Covered at 100%[1]
Outpatient Surgical Facility – Outpatient Ambulatory – Outpatient Hospital	 Covered at 100%[1] Covered at 100%[1]

BLUEADVANTAGE® EPO HSA $1,350/$2,700 100 CONTINUED

WITH A HEALTH SAVINGS ACCOUNT (HSA) OPTION AND INTEGRATED PRESCRIPTION DRUG BENEFIT

EMERGENCY SERVICES	IN NETWORK BENEFITS
Emergency Room	Covered at 100%[1]
Urgent Care Centers / Medical Aid Units	Covered at 100%[1]
Ambulance	Covered at 100%[1]
OTHER SERVICES	**IN NETWORK BENEFITS**
Inpatient Private Duty Nursing (up to 240 hours per 12 month period)	Covered at 100%[1]
Durable Medical Equipment (DME)	Covered at 100%[1]
Skilled Nursing Facility (up to 120 days per confinement)	Covered at 100%[1]
Home Health Care (up to 100 visits per Plan Year)	Covered at 100%[1]
Alcohol and Substance Abuse Treatment[2]	Covered same as medical
Serious Mental Health Care[2]	Covered same as medical
Other Mental Health Care	
– Inpatient and Partial Hospitalization (up to 31 inpatient days or 62 partial hospitalization days per Plan Year. Two partial hospitalization days reduce inpatient days by one day. One inpatient day reduces partial hospitalization days by two days.)	Covered at 100%[1]
– Outpatient (up to 20 visits per Plan Year)	Covered at 100%[1]
PRESCRIPTION DRUGS	
Per Prescription or Refill: UP TO A 90-DAY SUPPLY	
– Generic	Covered at 100%[1]
– Preferred Brand	Covered at 100%[1]
– Non-Preferred Brand	Covered at 100%[1]

See Note below. You should obtain professional legal or tax advice concerning allowable HSA contribution amounts for these options.

[1] Benefits are subject to a Plan Year deductible.

[2] Delaware law defines serious mental illness as nine diagnostic classes. Benefits for serious mental illness and substance abuse treatment are covered at the same levels as other medical care.

If individual coverage is elected, the individual deductible will apply. Benefits are then covered at the indicated percentage for each service until the coinsurance totals the individual coinsurance limit. Benefits will then be paid at 100% of the allowable charge for the individual for the remainder of the Plan Year.

If family coverage is elected, the family deductible will apply. The entire family deductible must be satisfied before benefits will be paid for any family member. Benefits are then covered at the indicated percentage for each service until the coinsurance totals the family coinsurance limit. Benefits will then be paid at 100% of the allowable charge for all family members for the remainder of the Plan Year.

When calculating deductible or coinsurance expenses, only the allowable charges are considered. All percentages listed above apply to Highmark Delaware's allowable charge.

There are no out-of-network benefits. EPO members can access in-network providers in the national BlueCard® Network across the country. You can access the network by searching online at bluecares.com or by calling a BlueCard customer service representative at 1.800.810.BLUE.

Note: The plan includes preferred coverage for organ transplants performed at Blue Distinction Centers for Transplants (BDCT). For transplants performed at participating but non-BDCT facilities, charges are covered at a reduced benefit level. Transplants performed at non-participating facilities are not covered.

Note: To establish and contribute to a Health Savings Account (HSA) you must be covered under a qualifying high deductible health plan (HDHP) and meet other eligibility requirements. These HDHPs are intended to be HSA-qualifying HDHPs. One of the other eligibility requirements is that you may not also be covered under another health plan that coordinates benefits with your HDHP, even if the other health plan also meets the requirements for an HDHP. You should obtain professional legal or tax advice before you establish or contribute to an HSA.

This Benefits Summary presents plan highlights only. It is not a contract. Please refer to your benefits booklet (or contact your marketing representative to request a copy) for complete information. All percentages are based on Highmark Delaware's allowable charge.

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