

# BLUEADVANTAGE® PPO HSA \$1,500/\$3,000 100/80

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

## PLAN YEAR DEDUCTIBLES (COMBINED IN/OUT OF NETWORK)

|                              |                                   |
|------------------------------|-----------------------------------|
| Individual                   | \$1,500                           |
| Family                       | \$3,000                           |
| Plan Year Coinsurance Limit: | Individual/Family \$4,450/\$8,900 |

| PREVENTIVE MEDICAL SERVICES         | IN NETWORK BENEFITS | OUT OF NETWORK BENEFITS |
|-------------------------------------|---------------------|-------------------------|
| Periodic Physical Exams             | Covered at 100%     | Covered at 80%          |
| Routine Annual GYN Exam             | Covered at 100%     | Covered at 80%          |
| Routine Mammogram                   | Covered at 100%     | Covered at 80%          |
| Routine Sigmoidoscopy & Colonoscopy | Covered at 100%     | Covered at 80%          |
| Routine Pap Smear                   | Covered at 100%     | Covered at 80%          |
| Routine Well-Child Care             | Covered at 100%     | Covered at 80%          |
| Immunizations                       | Covered at 100%     | Covered at 80%          |
| Routine Vision Exams                | Covered at 100%     | Covered at 80%          |
| Routine Hearing Exams               | Covered at 100%     | Covered at 80%          |
| Prostate Screening Antigen Test     | Covered at 100%     | Covered at 80%          |
| Lead Poisoning Screening Test       | Covered at 100%     | Covered at 80%          |

| TREATMENT OF ILLNESS OR INJURY   | IN NETWORK BENEFITS          | OUT OF NETWORK BENEFITS     |
|--|------------------------------|-----------------------------|
| Primary Doctor's Office Visits for Diagnosis & Treatment   | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| Specialist/Referral Care   | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| Laboratory Services  |                              |                             |
| – Independent  | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| – Hospital based   | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| Imaging & Machine Testing Services   |                              |                             |
| – Independent  | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| – Hospital based   | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| Outpatient High Tech Radiology Independent and Hospital Based (i.e. MRI, MRA, CT, CTA, PET scan) | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| Chiropractic (up to 30 visits per Plan year)   | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| Physical & Occupational Therapy (30 visits combined per Plan year)                               | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| Speech Therapy (30 visits per Plan Year)   | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| Radiation Therapy and Chemotherapy   | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| Inpatient Hospital   |                              |                             |
| – Semiprivate Room (including intensive care, if medically necessary)                            | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| – Physician's & Surgeon's Services   | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| – Other Medical Professional Services  | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| Maternity (hospital, birthing center and pre-natal and post-natal care)                          | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| Outpatient Surgical Facility   |                              |                             |
| – Outpatient Ambulatory  | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |
| – Outpatient Hospital  | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup> |

# BLUEADVANTAGE® PPO HSA \$1,500/\$3,000 100/80 CONTINUED

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

| EMERGENCY SERVICES   | IN NETWORK BENEFITS          | OUT OF NETWORK BENEFITS      |
|--|------------------------------|------------------------------|
| Emergency Room   | Covered at 100% <sup>1</sup> | Covered at 100% <sup>1</sup> |
| Urgent Care Centers / Medical Aid Units  | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup>  |
| Ambulance  | Covered at 100% <sup>1</sup> | Covered at 100% <sup>1</sup> |
| OTHER SERVICES   | IN NETWORK BENEFITS          | OUT OF NETWORK BENEFITS      |
| Inpatient Private Duty Nursing<br>(up to 240 hours per 12 month period)  | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup>  |
| Durable Medical Equipment (DME)  | Covered at 75% <sup>1</sup>  | Covered at 50% <sup>1</sup>  |
| Skilled Nursing Facility (up to 120 days per confinement)  | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup>  |
| Home Health Care (up to 100 visits per Plan Year)  | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup>  |
| Alcohol and Substance Abuse Treatment <sup>2</sup>   | Covered same as medical      | Covered same as medical      |
| Serious Mental Health Care <sup>2</sup>  | Covered same as medical      | 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% <sup>1</sup> | Covered at 80% <sup>1</sup>  |
| – Outpatient (up to 20 visits per Plan Year)   | Covered at 100% <sup>1</sup> | Covered at 80% <sup>1</sup>  |
| PRESCRIPTION DRUGS   |                              |                              |
| Per Prescription or Refill: UP TO A 90-DAY SUPPLY  |                              |                              |
| – Generic  | Covered at 100% <sup>1</sup> | Covered at 100% <sup>1</sup> |
| – Preferred Brand  | Covered at 80% <sup>1</sup>  | Covered at 80% <sup>1</sup>  |
| – Non-Preferred Brand  | Covered at 50% <sup>1</sup>  | Covered at 50% <sup>1</sup>  |

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

<sup>1</sup> Benefits are subject to a Plan Year deductible.

<sup>2</sup> 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.

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.**