

## Summary of PPOBlue Split Copayment 100/80 Benefits

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period.

### Municipal Employers Insurance Trust (MEIT)

| Benefit   | Network   | Out-of-Network                  |
|---|---|---------------------------------|
| <b>Benefit Period</b> (1)   | Contract Year                                   |                                 |
| <b>Deductible</b> (per benefit period)  |   |                                 |
| Individual  | None  | \$500                           |
| Family  | None  | \$1,000                         |
| <b>Plan Payment Level</b> – Based on the provider's reasonable charge (PRC)                             | 100%  | 80% after deductible            |
| <b>Out-of-Pocket Maximums</b> (Once met, plan payment level becomes 100%)                               |   |                                 |
| Individual  | \$3,000 Combined                                |                                 |
| Family  | \$6,000 Combined                                |                                 |
| <b>Autism Spectrum Disorders Maximum</b> (per person)(2)  | \$36,000/benefit period                         |                                 |
| <b>Lifetime Maximum</b> (per person)  | \$2,000,000 Combined                            |                                 |
| <b>Primary Care Physician Office Visits</b>   | 100% after \$20 copayment                       | 80% after deductible            |
| <b>Specialist Office Visits</b>   | 100% after \$40 copayment                       | 80% after deductible            |
| <b>Preventive Care</b>  |   |                                 |
| <i>Adult</i>  |   |                                 |
| Routine physical exams  | 100% after \$20 copayment                       | Not Covered                     |
| Adult Immunizations   | 100%  | 80% after deductible            |
| Colorectal Cancer Screening   |   |                                 |
| Diagnostic Services   | 100%  | 80% after deductible            |
| Medical Surgical  | 100%  | 80% after deductible            |
| Routine gynecological exams, including a Pap Test   | 100% after \$40 copayment                       | 80% (deductible does not apply) |
| Mammograms, annual routine and medically necessary  | 100%  | 80% after deductible            |
| <i>Pediatric</i>  |   |                                 |
| Routine physical exams  | 100% after \$20 copayment                       | Not Covered                     |
| Pediatric immunizations   | 100%  | 80% (deductible does not apply) |
| <b>Emergency Room Services</b>  | 100% after \$100 copayment (waived if admitted) |                                 |
| <b>Spinal Manipulations</b>   | 100% after \$40 copayment                       | 80% after deductible            |
|   | Limit: 20 visits/benefit period                 |                                 |
| <b>Physical Medicine</b>  | 100% after \$40 copayment                       | 80% after deductible            |
|   | Limit: 20 visits/benefit period                 |                                 |
| <b>Speech Therapy</b>   | 100% after \$40 copayment                       | 80% after deductible            |
|   | Limit: 20 visits/benefit period                 |                                 |
| <b>Occupational Therapy</b>   | 100% after \$40 copayment                       | 80% after deductible            |
|   | Limit: 20 visits/benefit period                 |                                 |
| <b>Allergy Extracts and Injections</b>  | 100%  | 80% after deductible            |
| <b>Ambulance</b>  | 80%   | 80% (deductible does not apply) |
| <b>Applied Behavior Analysis for Autism Spectrum Disorders</b> (2)                                      | 100% after deductible                           |                                 |
| <b>Assisted Fertilization Procedures</b>  | Not Covered                                     |                                 |
| <b>Dental Services Related to Accidental Injury</b>   | 100%  | 80% after deductible            |
| <b>Diabetes Treatment</b>   | 100%  | 80% after deductible            |
| <b>Diagnostic Services</b> (including routine)  |   |                                 |
| <i>Advanced Imaging</i> (MRI, CAT Scan, PET scan, etc.)   | 100%  | 80% after deductible            |
| <i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing) | 100%  | 80% after deductible            |

| <b>Benefit</b>  | <b>Network</b>   | <b>Out-of-Network</b>           |
|---|--|---------------------------------|
| <b>Durable Medical Equipment, Orthotics and Prosthetics</b>   | 80%  | 80% after deductible            |
| <b>Enteral Formulae</b>   | 100%   | 80% (deductible does not apply) |
| <b>Home Infusion Therapy</b>  | 100%   |                                 |
| <b>Home Health Care</b>   | 80%  | 80% after deductible            |
| <b>Hospice</b>  | 100%   | 80% after deductible            |
| <b>Hospital Services – Inpatient</b>  | 100%   | 80% after deductible            |
| <b>Hospital Services – Outpatient</b>   | 100%   | 80% after deductible            |
| <b>Infertility Counseling, Testing and Treatment<sup>(3)</sup></b>  | 100%   | 80% after deductible            |
| <b>Maternity</b> (facility & professional services)   | 100%   | 80% after deductible            |
| <b>Medical/Surgical Expenses</b> (except office visits)   | 100%   | 80% after deductible            |
| <b>Mental Health – Inpatient</b>  | 100%   | 80% after deductible            |
| <b>Mental Health – Outpatient</b>   | 100% after \$40 copayment  | 80% after deductible            |
| <b>Private Duty Nursing</b>   | 80%  | 80% (deductible does not apply) |
| <b>Respiratory Therapy</b>  | 100%   |                                 |
| <b>Skilled Nursing Facility Care</b>  | 80%  | 80% after deductible            |
|   | Limit: 100 days/benefit period   |                                 |
| <b>Substance Abuse</b>  |  |                                 |
| Inpatient Detoxification  | 100%   | 80% after deductible            |
| Inpatient Rehabilitation  | 100%   | 80% after deductible            |
| Outpatient  | 100% after \$40 copayment  | 80% after deductible            |
| <b>Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)   | 100%   | 80% after deductible            |
| <b>Transplant Services</b>  | 100%   | 80% after deductible            |
| <b>Precertification Requirements<sup>(4)</sup></b>  | Yes  |                                 |
| <b>Prescription Drug Deductible</b>   |  |                                 |
| Individual  | \$100 per Contract year  |                                 |
| Family  | \$200 per Contract year  |                                 |
| <b>Premier Prescription Drug Program</b><br>Mandatory Generic <sup>(5)</sup><br><i>Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i> | <b>Retail Drugs (31-day Supply)</b><br>Plan pays 70% after deductible<br>\$15 minimum member payment per prescription<br>\$100 maximum member payment per prescription<br><br><b>Maintenance Drugs through Mail Order (90-day Supply)</b><br>Plan pays 70% after deductible<br>\$30 minimum member payment per prescription<br>\$200 maximum member payment per prescription |                                 |

- (1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's renewal date. Contact your employer to determine the renewal date applicable to your program.
- (2) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
- (3) 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.
- (4) Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (5) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. To obtain a prescription medication that is not included on this formulary, your physician must complete the 'Prescription Drug Medication Request Form' and return it to the Pharmacy Affairs Department for clinical review. Under the mandatory generic provision, you are responsible for the payment differential when a generic drug is available and you or your doctor specifies a brand name drug. Your payment is the price difference between the brand drug and the generic drug in addition to the brand drug copayment or coinsurance amounts, which may apply.