This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.highmarkbcbs.com or by calling 1-800-241-5704.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** individual/**$6,000** family network, **$6,000** individual/**$12,000** family out-of-network. **Network deductible** does not apply to office visits, preventive care services, emergency room services, urgent care, rehabilitation services and prescription drug benefits. Copayments don't count toward the **network deductible.**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Network: **$0** individual/**$0** family out-of-pocket up to a total maximum out-of-pocket of **$6,350** individual/**$12,700** family Out-of-Network: **$6,000** individual/**$12,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

What is not included in the out–of–pocket limit?	Network: Premiums, balance-billed charges, prescription drug expenses and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-Network: Deductibles, copayments, prescription drug expenses, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **network providers,** see www.highmarkbcbs.com or call 1-800-241-5704.	If you use a **network** doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your **network** doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	20% coinsurance	——————————none——————————
	Specialist visit	$40 copay/visit	20% coinsurance	——————————none——————————
	Other practitioner office visit	$40 copay/visit for chiropractor	20% coinsurance for chiropractor	Combined network and out-of-network: 20 visits per benefit period.
	Preventive care Screening Immunization	No charge for preventive care services.	20% coinsurance for preventive care services	Please refer to your preventive schedule for additional information.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	——————————none——————————
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	——————————none——————————

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-800-241-5704.	Formulary Generic drugs	$8/$16/$24 copay (retail) $16 copay (mail order)	Not covered	Up to 31/60/90-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. Certain participating retail pharmacy providers may have agreed to make maintenance prescription drugs available at the same cost-sharing and quantity limits as the mail service coverage.
	Formulary Brand drugs	$45/$90/$135 copay (retail) $90 copay (mail order)	Not covered	Up to 31/60/90-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. Certain participating retail pharmacy providers may have agreed to make maintenance prescription drugs available at the same cost-sharing and quantity limits as the mail service coverage.

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
	Non-Formulary Brand and Non-Formulary Generic drugs	$95/$190/$285 copay (retail) $190 copay (mail order)	Not covered	Up to 31/60/90-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. Certain participating retail pharmacy providers may have agreed to make maintenance prescription drugs available at the same cost-sharing and quantity limits as the mail service coverage.

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
	Formulary Specialty drugs	$95 copay (retail) $190 copay (mail order)	Not covered	Up to 31-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. Certain participating retail pharmacy providers may have agreed to make maintenance prescription drugs available at the same cost-sharing and quantity limits as the mail service coverage.
	Non-Formulary Specialty drugs	25% coinsurance with a $200 maximum (retail) 25% coinsurance with a $400 maximum (mail order)	Not covered	Up to 31-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. Certain participating retail pharmacy providers may have agreed to make maintenance prescription drugs available at the same cost-sharing and quantity limits as the mail service coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	––––––––––none––––––––––
	Physician/surgeon fees	No charge	20% coinsurance	––––––––––none––––––––––

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$125 copay/visit	$125 copay/visit	Copay waived if admitted as an inpatient.
	Emergency medical transportation	No charge	No charge	Out-of-network: Subject to network deductible
	Urgent care	$75 copay/visit	20% coinsurance	––––––––––none––––––––––
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Precertification may be required.
	Physician/surgeon fee	No charge	20% coinsurance	––––––––––none––––––––––
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	20% coinsurance	––––––––––none––––––––––
	Mental/Behavioral health inpatient services	No charge	20% coinsurance	Precertification may be required.
	Substance use disorder outpatient services	No charge	20% coinsurance	––––––––––none––––––––––
	Substance use disorder inpatient services	No charge	20% coinsurance	Precertification may be required.
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information.
	Delivery and all inpatient services	No charge	20% coinsurance	Precertification may be required.

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Combined network and out-of-network: 90 visits per benefit period.
	Rehabilitation services	$40 copay/visit	20% coinsurance	Combined network and out-of-network: 20 physical medicine visits, 20 speech therapy visits and 20 occupational therapy visits per benefit period.
	Habilitation services	Not covered	Not covered	––––––––––none––––––––––
	Skilled nursing care	No charge	20% coinsurance	Combined network and out-of-network: 100 days per benefit period
	Durable medical equipment	No charge	20% coinsurance	––––––––––none––––––––––
	Hospice service	No charge	20% coinsurance	––––––––––none––––––––––
If your child needs dental or eye care	Eye exam	Not covered	Not covered	––––––––––none––––––––––
	Glasses	Not covered	Not covered	––––––––––none––––––––––
	Dental check-up	Not covered	Not covered	––––––––––none––––––––––

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See www.bcbsa.com
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-241-5704. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Highmark Inc. at 1-800-241-5704.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform .
- The Pennsylvania Department of Consumer Services at 1-877-881-6388.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To obtain language assistance, call 1-800-241-5704.

SPANISH (Español): Para obtener asistencia en Español, llame al **1-800-241-5704**.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-241-5704**.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 **1-800-241-5704**.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-241-5704**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,520
- **Patient pays** $3,020

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,000
Copays	$20
Coinsurance	$0
Limits or exclusions	$0
Total	**$3,020**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,100
- **Patient pays** $2,300

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,700
Copays	$600
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,300**

You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from **network providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

HIGHMARK. | PPO Blue

Summary of Connoisseur Media 3000 PPO Plan

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period)		
Individual	$3,000	$6,000
Family	$6,000	$12,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	None	$6,000
Family	None	$12,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays and other qualified medical expenses, Network only)(2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	$6,350	Not Applicable
Family	$12,700	Not Applicable
Autism Spectrum Disorders (ASD) Maximum (per person)(3)	$40,000/benefit period	
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $30 copayment	80% after deductible
Primary Care Provider Office Visits	100% after $30 copayment	80% after deductible
Specialist Office & Virtual Visits	100% after $40 copayment	80% after deductible
Virtual Visit Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after $75 copayment	80% after deductible
Preventive Care(4)		
Routine Adult		
Physical exams	100%	80% after deductible
Adult immunizations	100%	80% after deductible
Colorectal cancer screening	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100%	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
Routine Pediatric		
Physical exams	100%	80% after deductible
Pediatric immunizations	100%	80% (deductible does not apply)
Diagnostic services and procedures	100%	80% after deductible

Benefit	Network	Out-of-Network
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	
Medical Care (including inpatient visits and consultations)**/Surgical Expenses**	100% after deductible	
Emergency Services		
Emergency Room Services	100% after $125 copayment (waived if admitted)	
Ambulance	100% after deductible	100% after in network deductible
Ambulance – Non-Emergency	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after $40 copayment	80% after deductible
	Limit: 20 visits/benefit period	
Respiratory Therapy	100% after deductible	80% after deductible
Speech & Occupational Therapy	100% after $40 copayment	80% after deductible
	Limit: 20 visits per therapy/benefit period	
Spinal Manipulations	100% after $40 copayment	80% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health/Substance Abuse		
Inpatient	100% after deductible	80% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible	
Outpatient	100% after deductible	
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Applied Behavior Analysis for Autism Spectrum Disorders(3)	100% after deductible	
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	Not Covered	Not Covered
Diagnostic Services *Advanced Imaging* (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	Limit: 90 days/benefit period	
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment(5)	100% after deductible	80% after deductible

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.

Benefit	Network	Out-of-Network
Private Duty Nursing	100% after deductible	80% after deductible
	Limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	Limit: 100 days/benefit period	
Transplant Services	100% after deductible	80% after deductible
Precertification Requirements(6)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual Family	 None None	
Prescription Drug Program(7) Hard Mandatory Generic *Defined by the Premier 2012 Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Incentive Formulary with an Progressive Formulary Benefit Design.*	**Retail Drugs (31/60/90-day Supply)** $8/$16/$24 formulary generic copayment $45/$90/$135 formulary brand copayment $95/$190/$285 non-formulary brand, non-formulary generic and formulary specialty copayment Member pays 25% for non-formulary specialty drugs $200 maximum member payment per prescription **Maintenance Drugs through Mail Order (90-day Supply)** $16 formulary generic copayment $90 formulary brand copayment $190 non-formulary brand, non-formulary generic and formulary specialty copayment Member pays 25% for non-formulary specialty drugs $400 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 effective date. Contact your employer to determine the effective date applicable to your program.

(2) Effective with plan years beginning on or after January 1, 2014 the Network Total Maximum Out-of-Pocket as mandated by the federal government must include deductible, coinsurance, copays, and any qualified medical expense. The Total Maximum Out-of-Pocket cannot be more than $6,350 for individual and $12,700 for two or more persons.

(3) Coverage for eligible members to age 26. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.

(4) Services are limited to those listed on the Highmark Health Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.

(5) 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.

(6) Highmark Health Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. 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.

(7) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the

specific copayment or coinsurance amounts listed above.Under the hard mandatory generic provision, you are responsible for the payment differential when a generic drug is available and you or your provider specifies a brand name drug. Your payment is the price difference between the brand name drug and the generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply. Selected specialty drugs are limited to a 31-day supply.