

Small Business Program
PPOBlue Benefit Summary
PPOBlue Value 1000 w/ Rx 8/35/50



| PAYMENT LEVEL | IN-NETWORK DEDUCTIBLE | OFFICE VISITS | EMERGENCY ROOM SERVICES |
|---------------|-----------------------|-----------------|-------------------------|
| 100%/80% | \$1,000/\$2,000 | \$20/\$30 COPAY | \$100 COPAY |

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 care. There is no requirement to select a Primary Care Physician (PCP) to coordinate care. Below are specific benefit levels that apply during your benefit period.

| BENEFITS | IN-NETWORK | OUT-OF-NETWORK |
|---|--|--|
| Benefit Period | Contract Year <i>Twelve consecutive months beginning on the contract date</i> | |
| Deductible Per Benefit Period | \$1,000 Individual \$2,000 Family Aggregate | \$2,000 Individual \$4,000 Family Aggregate |
| Payment Level <i>Based on Provider's Reasonable Charge (PRC)</i> | 100% PRC after deductible | 80% PRC after deductible until out-of-pocket limit is met; then 100% PRC |
| Out-of-Pocket Limit <i>Includes Coinsurance, certain exclusions may apply</i> | Not Applicable | \$2,000 Individual \$4,000 Family Aggregate |
| Lifetime Maximum | Unlimited | |
| Ambulance | 100% PRC after deductible | 80% PRC after deductible |
| Assisted Fertilization Procedures | Not Covered | Not Covered |
| Dental Services Related to an Accidental Injury | Not Covered | Not Covered |
| Diabetes Treatment | 100% PRC after deductible | 80% PRC after deductible |
| Diagnostic Services (including routine and pre-admission testing) <i>Advanced Imaging (MRI, CAT scan, PET scan, etc.)</i> | 100% PRC after deductible | 80% PRC after deductible |
| <i>Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</i> | 100% PRC after deductible | 80% PRC after deductible |
| Durable Medical Equipment, Orthotics and Prosthetics | 100% PRC after deductible | 80% PRC after deductible |
| Emergency Room Services | 100% PRC after \$100 Copay – waived if admitted | |
| Enteral Formulae | 100% PRC no deductible | 80% PRC no deductible |
| Hearing Care Services | Not Covered | Not Covered |
| Home Health Care <i>Excludes Respite Care</i> | 100% PRC after deductible | 80% PRC after deductible |
| | ----- 90 visits/benefit period | |
| Hospice <i>Includes Respite Care</i> | 100% PRC after deductible | 80% PRC after deductible |
| Hospital Expenses <i>Inpatient and Outpatient</i> | 100% PRC after deductible | 80% PRC after deductible |
| Infertility Counseling, Testing and Treatment <i>Treatment includes coverage for the correction of a physical or medical problem associated with infertility.</i> | 100% PRC after deductible | 80% PRC after deductible |
| Maternity Includes Dependent Daughters | 100% PRC after deductible | 80% PRC after deductible |
| Medical Care <i>Includes Inpatient Visits and Consultations</i> | 100% PRC after deductible | 80% PRC after deductible |
| Mental Health Inpatient ① | 100% PRC after deductible | 80% PRC after deductible |
| Mental Health Outpatient ① | 100% PRC after deductible | 80% PRC after deductible |
| Office Visits <i>Primary Care Physician</i> <i>Specialty Care Physician</i> | 100% PRC after \$20 Copay 100% PRC after \$30 Copay | 80% PRC after deductible 80% PRC after deductible |
| Oral Surgery | 100% PRC after deductible | 80% PRC after deductible |
| Physical Medicine Outpatient | 100% PRC after \$30 Copay | 80% PRC after deductible |
| | ----- 20 visits/benefit period | |

| PRESCRIPTION DRUG BENEFIT | |
|--|--|
| Deductible <i>(per benefit period)</i> | None |
| Prescription Drug Program | <p style="text-align: center;">Retail Drugs (31-/60-/90-day Supply) \$8/\$16/\$24 Generic Copay \$35/\$70/\$105 Brand Formulary Copay \$50/\$100/\$150 Brand Non-Formulary Copay</p> <p style="text-align: center;">Maintenance Drugs through Mail Order (90-day Supply) \$20 Generic Copay \$90 Brand Formulary Copay \$125 Brand Non-Formulary Copay</p> |
| Formulary | Incentive |
| Generic Substitution | Soft -When you purchase a brand drug that has a generic equivalent you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs, unless your physician requests that the brand name drug be dispensed |
| Out-of-Pocket Maximum | Not Applicable |
| Claim Submission | Pharmacy Files at Point-of-Sale |
| Non-Network Pharmacy | Not Covered |
| PRESCRIPTION DRUG CATEGORIES | |
| Contraceptives <i>(oral and injectable)</i> | Covered |
| Fertility Agents | Covered |
| Fluoride Products | Covered |
| Insulin and Diabetic Supplies | Covered |
| Smoking Deterrents <i>(prescription)</i> | Covered |
| Vitamins <i>(prescription)</i> | Covered |
| Weight Loss Drugs | Covered |
| Allergy Serum | Not Covered |
| Durable Medical Equipment | Not Covered |
| Prescription Hair Growth Products | Not Covered |
| CARE MANAGEMENT PROGRAMS | |
| Exclusive Pharmacy Provider | Applies - selected high cost prescription drugs are covered only when they are dispensed through an exclusive pharmacy provider. |
| Quantity Level Limits <i>on select prescription drugs</i> | Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines. |
| Managed Rx Coverage <i>on certain drug therapies</i> | Applies – certain drug therapies may be monitored for appropriate usage and subject to case evaluation if recommended guidelines are exceeded.. |
| Managed Prior Authorizations | Applies on select high cost drugs. |