Highmark Delaware: Blue Advantage HSA EPO - $3,000/$9,000 **Coverage Period:** Beginning on or after 01/01/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs. **Coverage for:** Individual/Family **Plan Type:** HSA EPO

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.highmarkbcbsde.com** or by calling **1-800-633-2563**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$3,000 Individual / $9,000 Family; does not apply to preventive services.	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 2 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 startong on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. $5,950 Individual / $11,900 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?	Premiums, balance-billed charges, any copays, and health care this plan does not 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 2 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. Go to www.Highmarkbcbsde.com or call 1-800-633-2563 for a list of in-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-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 2 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 section *Services Your Plan Does NOT Cover*. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-633-2563** or visit us at **www.Highmarkbcbsde.com.**
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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 and you have met your deductible, your **co-insurance** payment of 20% would be $200. This may change if you haven't met any of 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 **participating providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-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	No charge	Not covered	None
	Specialist visit	No charge	Not covered	None
	Other practitioner office visit	No charge	Not covered	Coverage is limited to 30 visits per plan year for chiropractic care.
	Preventive care / screening / immunizations	No charge	Not covered	Coverage is limited by age, gender and risk parameters as identified in Highmark Delaware's Preventive Health Guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT / PET scans, MRIs)	No charge	Not covered	None

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at .	Generic drugs	No charge	No charge	Some drugs require prior authorization and/or have quantity limits.
	Preferred brand drugs	25% coinsurance	25% coinsurance	Some drugs require prior authorization and/or have quantity limits.
	Non-preferred brand drugs	50% coinsurance	50% coinsurance	Some drugs require prior authorization and/or have quantity limits.
	Specialty drugs	No charge	Same as in Network	Some drugs require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	None
	Physician / surgeon fee	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	Care must be rendered within 48 hours of onset of symptoms.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	No charge	Not covered	None
If you have a hospital stay	Facility fee (e.g. hospital room)	20% coinsurance	Not covered	Unauthorized care will be denied.
	Physician / surgeon fee	20% coinsurance	Not covered	Unauthorized care will be denied.

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Common Medical Event	Services You May Need	Your cost if you use an In-network provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	No charge	Not covered	Non-parity services limited to 20 visits per plan year.
	Mental / Behavioral health inpatient services	Professional-20% coinsurance / Facility-20% coinsurance	Professional-Not covered / Facility-No Covered	Non-parity services limited to 31 days per plan year. Unauthorized care will be denied.
	Substance use disorder outpatient services	No charge	Not covered	None
	Substance use disorder inpatient services	Professional-20% coinsurance / Facility-20% coinsurance	Not covered	Unauthorized care will be denied.
If you are pregnant	Prenatal and postnatal care	Not covered	Not covered	Maternity is not covered.
	Delivery and all inpatient services	Not covered	Not covered	Maternity is not covered.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Coverage is limited to 100 visits per plan year. Unauthorized care will be denied.
	Rehabilitation services	No charge	Not covered	Coverage is limited to 30 visits per plan year.
	Habilitation services	Not covered	Not covered	No coverage for habilitation services.
	Skilled nursing care	Professional-20% coinsurance / Facility-20% coinsurance	Not covered	Coverage is limited to 120 days per benefit period. Unauthorized care will be denied.
	Durable medical equipment	20% coinsurance	Not covered	None
	Hospice service	20% coinsurance	Not covered	None

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If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage is limited to one routine visit per plan year.
	Glasses	Not covered	Not covered	No coverage for glasses.
	Dental check-up	Not covered	Not covered	No coverage for dental check-up.

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
- Care in Residental Facilities
- Dental Care
- Habilitation Services
- Maternity
- Weight Loss Programs
- Bariatric Surgery
- Cosmetic Surgery
- Experimental/Investigational Care
- Infertility Treatment
- Non-emergency Care Outside US
- Worker's Compensation Claims
- Care by Family Members
- Custodial Care/Rest Homes
- Glasses
- Long-Term Care
- Routine Foot Care

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.)

- Chiropractic Care
- Routine Eye Care (Adult)
- Hearing Aids
- Inpatient Private-Duty Nursing

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You Commit fraud
- The Insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 800.633.2563. You may also contact your state insurance department at
www.delawareinsurance.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:

- The Delaware Department of Insurance /Consumer Assistance Program:
  841 Silver Lake Blvd, Dover, DE 19904, or 302.674.7300 (local), 800.282.8611 (toll free), or consumer@state.de.us.
- Additionally, the Delaware Department of Insurance/Consumer Assistance Program can help you file your appeal.

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 the 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	$0
■ Patient pays	$7,540

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	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$7,540
Total	**$7,540**

Note: These numbers assume the patient has given notice of her pregnancy to the plan.If you are pregnant and have not given notice of your pregnancy,your costs may be higher.For more information please contact: www.Highmarkbcbsde.com/Members/HealthWellness/Coping

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

■ Amount owed to providers:	$5,400
■ Plan pays	$3,920
■ Patient pays	$1,480

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	$1,150
Co-pays	$0
Co-insurance	$250
Limits or exclusions	$80
Total	**$1,480**

Note: These numbers assume the patient is participatingin our diabetes welness program.if you have diabetes and do not participate in wellness program costs may be higher.For more information
please contact:
www.Highmarkbcbsde.com/Members/HealthWellness/Coping

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 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 in-network providers. If the patient had received 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, co-payments, and co-insurance 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 the 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 co-payments, deductibles, and co-insurance. 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.