

Plan Year Deductibles¹

Individual \$1,800
 Family \$3,600
 Out of Network Plan Year coinsurance limit: Individual/Family \$3,450/\$6,900

Preventive Medical Services	In Network Benefits	Out of Network Benefits
• Periodic Physical Exams	Covered at 100%	Not covered
• Routine Annual GYN Exam	Covered at 100%	Not covered
• 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%	Not covered
• Immunizations	Covered at 100%	Covered at 80%
• Routine Vision Exams	Covered at 100%	Not covered
• Routine Hearing Exams	Covered at 100%	Not covered
• 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% ¹	Covered at 80% ¹
• Specialist/Referral Care	Covered at 100% ¹	Covered at 80% ¹
• Laboratory Services <ul style="list-style-type: none"> o Independent o Hospital based 	Covered at 100% ¹ Covered at 100% ¹	Covered at 80% ¹ Covered at 80% ¹
• Imaging & Machine Testing Services <ul style="list-style-type: none"> o Independent o Hospital based 	Covered at 100% ¹ Covered at 100% ¹	Covered at 80% ¹ Covered at 80% ¹
• Outpatient High Tech Radiology Independent and Hospital Based (i.e. MRI, MRA, CT, CTA, PET scan)	Covered at 100% ¹	Covered at 80% ¹
• Chiropractic (up to 30 visits per Plan year)	Covered at 100% ¹	Covered at 80% ¹
• Physical & Occupational Therapy (30 visits combined per Plan year)	Covered at 100% ¹	Covered at 80% ¹
• Speech Therapy (30 visits per Plan Year)	Covered at 100% ¹	Covered at 80% ¹
• Radiation Therapy and Chemotherapy	Covered at 100% ¹	Covered at 80% ¹
• Inpatient Hospital <ul style="list-style-type: none"> o Semiprivate Room (including intensive care, if medically necessary) o Physician's & Surgeon's Services o Other Medical Professional Services 	Covered at 100% ¹ Covered at 100% ¹ Covered at 100% ¹	Covered at 80% ¹ Covered at 80% ¹ Covered at 80% ¹
• Maternity (hospital, birthing center, pre-natal and post-natal care)	Not covered	Not covered
• Outpatient Surgical Facility <ul style="list-style-type: none"> o Outpatient Ambulatory o Outpatient Hospital 	Covered at 100% ¹ Covered at 100% ¹	Covered at 80% ¹ Covered at 80% ¹

Emergency Services	In Network Benefits	Out of Network Benefits
• Emergency Room	Covered at 100% ¹	Covered at 100% ¹
• Urgent Care Centers / Medical Aid Units	Covered at 100% ¹	Covered at 80% ¹
• Ambulance	Covered at 100% ¹	Covered at 80% ¹
Other Services	In Network Benefits	Out of Network Benefits
• Inpatient Private Duty Nursing (up to 240 hours per 12 month period)	Covered at 100% ¹	Covered at 80% ¹
• Durable Medical Equipment (DME)	Covered at 100% ¹	Covered at 80% ¹
• Skilled Nursing Facility (up to 120 days per confinement)	Covered at 100% ¹	Covered at 80% ¹
• Home Health Care (up to 100 visits per Plan Year)	Covered at 100% ¹	Covered at 80% ¹
• Alcohol and Substance Abuse Treatment ²	Covered same as medical	Covered Same as medical
• Serious Mental Health Care ²	Covered same as medical	Covered Same as medical
• Other Mental Health Care		
o 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% ¹	Covered at 80% ¹
o Outpatient (up to 20 visits per Plan Year)	Covered at 100% ¹	Covered at 80% ¹
Prescription Drugs		
Per Prescription or Refill: UP TO A 90-DAY SUPPLY		
• Generic	Covered at 100% ¹	
• Preferred Brand	Covered at 100% ¹	
• Non-Preferred Brand	Covered at 100% ¹	

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

1 Benefits are subject to a Plan Year deductible. Please note that there are separate, but equal, in and out of network deductibles, which do not aggregate.

2 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.

Blue Individual plans do not cover maternity services or bariatric surgery. The plan includes preferred coverage for organ transplants performed at the 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.

When calculating deductible or coinsurance expenses, only the allowable charges are considered. All percentages listed above apply to Highmark Delaware's allowable charge.

Members can access in-network providers in the national BlueCard® Network across the country. You can access the network by searching online at bluecares.com or by calling a BlueCard customer service representative at **1-800-810-BLUE (2583)**.

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 benefit outline presents plan highlights only. It is not a contract, and it is not a Summary of Benefits and Coverage (SBC) as required by federal law. You can obtain an SBC by visiting www.highmarkbcbsde.com or calling 1-800-633-2563.

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