



Services	Benefits
<p>Hospital Benefits</p> <p>(Including care for substance abuse and serious mental illness.)</p>	<p>Inpatient Facility: \$100 copayment per day per individual for the first 10 days of each admission; then covered at 100% of Blue Cross Blue Shield's (BCBSD's) allowable charge. Benefits limited to 30 days per confinement and must be separated by 90 days without care.</p> <p>Outpatient Facility: \$25 copayment per day for emergency accident services; then paid at 100% of BCBSD's allowable charge. Copayment waived if admitted to a hospital.</p>
<p>Preventative Care</p>	<p>Preventative Care: Covered 100% of BCBSD's allowable cost</p>
<p>Surgical-Medical Benefits</p> <p>(Including care for substance abuse and serious mental illness.)</p>	<p>Inpatient Physician: Covered at 70% of BCBSD's allowable charge for the period during which facility charges are covered.</p> <p>Outpatient Physician Surgical Services: \$50 copayment per surgical procedure; then paid at 100% of BCBSD's allowable charge.</p>
<p>Diagnostic & Therapeutic Benefits</p>	<p>Covered at 100% of BCBSD's allowable charge. \$100 benefit payment maximum per outpatient diagnostic test or therapy treatment. Physical and occupational therapy have a combined 30 visits per calendar year limit. Speech therapy has a separate 30 visits per calendar year.</p>
<p>Pre-admission Testing</p>	<p>Covered at 100% of BCBSD's allowable charge.</p>
<p>Benefits Subject to the Deductible</p>	<p>\$750 individual/\$1,500 family deductible per calendar year, then covered at 70% of BCBSD's allowable charge.</p> <p>Skilled Nursing Facility: (120 days per admission maximum)</p> <p>Home Health Care from coordinated Home Care program or Visiting Nurse Agency (100 visits per calendar year maximum. This benefit excludes coverage for prescription drugs.)</p> <p>Hospice: (240 consecutive calendar days of service maximum)</p> <p>Office Visits: (including care for substance abuse and serious mental illness)</p> <p>Chiropractic Visits: (limit 30 per calendar year)</p> <p>Prescription Drugs: (includes drugs dispensed by Home Health Care agencies; excludes coverage for needles, syringes or insulin)</p>
<p>Non-Parity Benefits</p>	<p>Inpatient Mental Health Care—Facility & Physician: 70% covered for 31 days per calendar year. Days aggregate with partial hospitalization, two for one.</p> <p>Partial Hospitalization: 70% covered for 31 days per calendar year. Days aggregate with inpatient mental health care, two for one.</p> <p>Outpatient Mental Health Care: 70% covered.</p> <p>Deductibles: A separate calendar year deductible (\$750 individual; \$1,500 family) applies to both inpatient and outpatient mental health and non-authorized substance abuse services.</p>

Two individuals must meet the deductible for the family deductible to be met. All calculations of your deductible amounts and our benefit payments are based on BCBSD's allowable charges.

There is no coverage for human organ transplants, ambulance service, private duty nursing, medical emergency services or bariatric surgery. Managed Care is a component of the BCBSD Conversion Plan.

All mental health and substance abuse care is managed through the Managed Care Program offered as part of your mental health/substance abuse treatment benefit plan. All care must be authorized in advance by the Case Management Center and must be conducted by a provider specified by the Case Management Center to ensure full benefits.

Substance abuse parity guidelines apply. If Services are authorized and all managed care guidelines are followed, substance abuse services are covered at the same level as any other medical care. If managed care guidelines are not followed, then the non-authorized benefits apply. Coverage for non-authorized substance abuse services is limited to 31 inpatient or 62 partial hospital days during one 270 day period per lifetime. Outpatient office visits are not covered.

Individual contracts do not cover services rendered for preexisting conditions for 12 months from the original date your BCBSD coverage begins. In calculating when the 12-month period is met, we will count the time you are continuously covered by us under another individual or Group Contract. The coverage must have immediately preceded this individual contract, with no lapse in coverage.

This Benefits Summary presents plan highlights only. It is not a contract. For more information, contact a BCBSD Customer Service Representative at 302.429.0260 or 800.633.2563. Blue Cross Blue Shield of Delaware is an independent licensee of the Blue Cross and Blue Shield Association.