Highmark Delaware: Simply Blue EPO

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:** 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?	In-Network $2,000 Individual / $6,000 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?	Yes. Prescription drugs: $500 Individual; does not apply to generic drugs. There are no other specific deductibles.	You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. In-Network $5,000 Individual / $10,000 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?	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*, below. 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.**
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call **1-800-633-2563** to request a copy.

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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 a		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per day	Not Covered	None
	Specialist visit	$45 copay per day	Not Covered	None
	Other practitioner office visit	$45 copay per day for chiropractic care	Not Covered	Coverage is limited to 30 visits per plan year.
	Preventive care / screening / immunization	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)	Hospital-based facility: 20% coinsurance; Independent provider: $10 copay per day	Not Covered	None
	Imaging (CT / PET scans, MRIs)	20% coinsurance	Not Covered	Unauthorized care will be denied.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a 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 www.highmarkbcbsde.com/Members/Rx	Generic drugs	$15	Same as In-Network	Some drugs require prior authorization and/or have quantity limits.
	Preferred brand drugs	25%	Same as In-Network	Generic substitution required. Some drugs require prior authorization and/or have quantity limits.
	Non-preferred brand drugs	50%	Same as In-Network/Par	Generic substitution required. Some drugs require prior authorization and/or have quantity limits.
	Specialty drugs	PCP: $20 copay per day; Specialist: $45 copay per day	Same as in Network	Some drugs require prior authorization and/or have quantity limits.
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	$150 copay per day	$150 copay per day	Care must be rendered within 48 hours of onset of symptoms.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$45 copay per day	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.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	$45 copay per day	Not Covered	Non-parity benefit limited to 20 visits per calendar year
	Mental / Behavioral health inpatient services	Professional-20% coinsurance Facility-20% coinsurance	Professional-Not Covered /Facility-Not Covered	Non-parity benefits limited to 31 days per calendar year. Unauthorized care will be denied.
	Substance use disorder outpatient services	$45 copay per day	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	20% coinsurance	Not Covered	None
	Delivery and all inpatient services	Professional-20% coinsurance Facility-20% coinsurance	Not Covered	None
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 calendar year. Unauthorized care will be denied.
	Rehabilitation services	$45 copay per day	Not Covered	Coverage is limited to 30 visits per plan year for Physical Therapy and Occupational Therapy; 30 visits per plan year for Speech Therapy.
	Habilitation services	Not Covered	Not Covered	No coverage for habilitation services.

If you need help recovering or have other special health needs	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	Coverage is limited to 240 days per lifetime. Unauthorized inpatient care will be denied.
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
- Bariatric Surgery
- Care by Family Members
- Care in Residential Facilities
- Cosmetic Surgery
- Custodial Care/Rest Homes
- Dental Care
- Experimental/Investigational Care
- Glasses
- Habilitation Services
- Infertility Treatment
- Long-Term Care
- Non-emergency Care Outside US
- Routine Foot Care
- Weight Loss Programs
- Worker's Compensation Claims

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

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 (302) 674-7300. 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.

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-800.633.2563.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800.633.2563.
- Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800.633.2563.
- Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800.633.2563.

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** $4,280
- **Patient pays** $3,260

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	$2,000
Co-pays	$180
Co-insurance	$930
Limits or exclusions	$150
Total	**$3,260**

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** $3,320
- **Patient pays** $2,080

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	$600
Co-insurance	$250
Limits or exclusions	$80
Total	**$2,080**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, 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.