BLUEADVANTAGE® EPO HRA $25 $2,500 80 (Alternative)

WITH A HEALTH REIMBURSEMENT ARRANGEMENT (HRA) OPTION

PLAN YEAR DEDUCTIBLES	
Individual	$2,500
Family	$5,000
Plan Year Coinsurance Limit	Individual/Family $2,500/$5,000
PREVENTIVE MEDICAL SERVICES	**IN NETWORK BENEFITS**
Periodic Physical Exams	Covered at 100%
Routine Annual GYN Exam	Covered at 100%
Routine Mammogram	Covered at 100%
Routine Sigmoidoscopy & Colonoscopy	Covered at 100%
Routine Pap Smear	Covered at 100%
Routine Well-Child Care	Covered at 100%
Immunizations	Covered at 100%
Routine Vision Exams	Covered at 100%
Routine Hearing Exams	Covered at 100%
Prostate Screening Antigen Test	Covered at 100%
Lead Poisoning Screening Test	Covered at 100%
TREATMENT OF ILLNESS OR INJURY	**IN NETWORK BENEFITS**
Primary Doctor's Office Visits for Diagnosis & Treatment	$25 copay per visit
Specialist/Referral Care	$50 copay per visit
Laboratory Services – Independent – Hospital based	 $10 copay per visit Covered at 80%[1]
Imaging & Machine Testing Services – Independent – Hospital based	 $50 copay per visit Covered at 80%[1]
Outpatient High Tech Radiology Independent and Hospital Based (i.e. MRI, MRA, CT, CTA, PET scan)	Covered at 80%[1]
Chiropractic (up to 30 visits per Plan year)	Covered at 80%[1]
Physical & Occupational Therapy (30 visits combined per Plan year)	Covered at 80%[1]
Speech Therapy (30 visits per Plan Year)	Covered at 80%[1]
Radiation Therapy and Chemotherapy	Covered at 80%[1]
Inpatient Hospital – Semiprivate Room (including intensive care, if medically necessary) – Physician's & Surgeon's Services – Other Medical Professional Services	 Covered at 80%[1] Covered at 80%[1] Covered at 80%[1]
Maternity (hospital, birthing center and pre-natal and post-natal care)	Covered at 80%[1]
Outpatient Surgical Facility – Outpatient Ambulatory – Outpatient Hospital	 Covered at 100%[1] Covered at 80%[1]

BLUEADVANTAGE® EPO HRA $25 $2,500 80 (Alternative) CONTINUED

WITH A HEALTH REIMBURSEMENT ARRANGEMENT (HRA) OPTION

EMERGENCY SERVICES	IN NETWORK BENEFITS
Emergency Room	Covered at 80%[1]
Urgent Care Centers / Medical Aid Units	$50 copay per visit
Ambulance	Covered at 80%[1]
OTHER SERVICES	**IN NETWORK BENEFITS**
Inpatient Private Duty Nursing (up to 240 hours per 12 month period)	Covered at 80%[1]
Durable Medical Equipment (DME)	Covered at 75%[1]
Skilled Nursing Facility (up to 120 days per confinement)	Covered at 80%[1]
Home Health Care (up to 100 visits per Plan Year)	Covered at 80%[1]
Alcohol and Substance Abuse Treatment[2]	Covered same as medical
Serious Mental Health Care[2]	Covered same as medical
Other Mental Health Care	
– 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 80%[1]
– Outpatient (up to 20 visits per Plan Year)	$50 copay per visit
PRESCRIPTION DRUGS	
Prescription Drugs	See "Your Prescription Drug Program"

You should obtain professional legal or tax advice regarding a Health Reimbursement Arrangement (HRA).

[1]Benefits are subject to a Plan Year deductible.

[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.

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

Note: Applicable copays still apply after coinsurance expense limit has been reached.

Note: The plan includes reduced coverage for bariatric surgeries and preferred coverage for organ transplants performed at 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.

There are no out-of-network benefits. EPO 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 800.810.BLUE.

This Benefits Summary presents plan highlights only. It is not a contract. Please refer to your benefits booklet (or contact your marketing representative to request a copy) for complete information. All percentages are based on Highmark Delaware's allowable charge.

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