BLUE CHOICE® PPO $25 $500/$1,500 80/60

PLAN YEAR DEDUCTIBLES	IN NETWORK BENEFITS	OUT OF NETWORK BENEFITS
Individual	$500	$1,000
Family	$1,500	$2,000
Coinsurance Limit	Individual/Family $1,500/$2,500	Individual/Family $4,000/$8,000
PREVENTIVE MEDICAL SERVICES	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Periodic Physical Exams	Covered at 100%	Covered at 60%
Routine Annual GYN Exam	Covered at 100%	Covered at 60%
Routine Mammogram	Covered at 100%	Covered at 60%
Routine Sigmoidoscopy & Colonoscopy	Covered at 100%	Covered at 60%
Routine Pap Smear	Covered at 100%	Covered at 60%
Routine Well-Child Care	Covered at 100%	Covered at 60%
Immunizations	Covered at 100%	Covered at 60%
Routine Vision Exams	Covered at 100%	Covered at 60%
Routine Hearing Exams	Covered at 100%	Covered at 60%
Prostate Screening Antigen Test	Covered at 100%	Covered at 60%
Lead Poisoning Screening Test	Covered at 100%	Covered at 60%
TREATMENT OF ILLNESS OR INJURY	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Primary Doctor's Office Visits for Diagnosis & Treatment	$25 copay per visit	Covered at 60%[1]
Specialist/Referral Care	$40 copay per visit	Covered at 60%[1]
Laboratory Services – Independent – Hospital based	 $10 copay per visit Covered at 80%[1]	 Covered at 60%[1] Covered at 60%[1]
Imaging & Machine Testing Service – Independent – Hospital based	 $40 copay per visit Covered at 80%[1]	 Covered at 60%[1] Covered at 60%[1]
Outpatient High Tech Radiology Independent and Hospital Based (i.e. MRI, MRA, CT, CTA, PET scan)	Covered at 80%[1]	Covered at 60%[1]
Chiropractic (up to 30 visits per Plan year)	Covered at 80%[1]	Covered at 75%[1]
Physical & Occupational Therapy (30 visits combined per Plan Year)	Covered at 80%[1]	Covered at 60%[1]
Speech Therapy (30 visits per Plan Year)	Covered at 80%[1]	Covered at 60%[1]
Radiation Therapy and Chemotherapy	Covered at 100%[1]	Covered at 60%[1]
Inpatient Hospital – Semiprivate Room (including intensive care, if medically necessary) – Physician's & Surgeon's Services – Other Medical Professional Services	 Covered at 100%[1] Covered at 100%[1] Covered at 100%[1]	 Covered at 60%[1] Covered at 60%[1] Covered at 60%[1]
Maternity (hospital, birthing center, pre-natal and post-natal care)	Covered at 100%[1]	Covered at 60%[1]
Outpatient Surgical Facility – Outpatient Ambulatory – Outpatient Hospital	 Covered at 100%[1] Covered at 100%[1]	 Covered at 60%[1] Covered at 60%[1]

BLUE CHOICE® PPO $25 $500/$1,500 80/60 CONTINUED

EMERGENCY SERVICES	IN NETWORK BENEFITS	OUT OF NETWORK BENEFITS
Emergency Room	$150, waived if admitted	Covered same as In Network[1]
Urgent Care Centers / Medical Aid Units	$40 copay per visit	Covered at 60%[1]
Ambulance	Covered at 80%[1]	Covered same as In Network[1]
OTHER SERVICES	**IN NETWORK BENEFITS**	**OUT OF NETWORK BENEFITS**
Inpatient Private Duty Nursing (up to 240 hours per 12 month period)	Covered at 80%[1]	Covered at 60%[1]
Durable Medical Equipment (DME)	Covered at 75%[1]	Covered at 60%[1]
Skilled Nursing Facility (up to 120 days per confinement)	Covered at 100%[1]	Covered at 60%[1]
Home Health Care (up to 100 visits per Plan Year)	Covered at 100%[1]	Covered at 60%[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		
– 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 60%[1]
– Outpatient (up to 20 visits per Plan Year)	$40 copay per visit	Covered at 60%[1]
PRESCRIPTION DRUGS		
Prescription Drugs	See "Your Prescription Drug Program"	

[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.

PPO members can receive care with 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.

Note: The plan includes reduced coverage for bariatric surgeries and 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.

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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