BLUE CARE® IPA $15/$25 100

PLAN YEAR DEDUCTIBLES	
Individual	None
Family	None
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	$15 copay per visit
Specialist/Referral Care	$25 copay per visit
Laboratory Services – Independent – Hospital based	 $10 copay per visit $50 copay per visit
Imaging & Machine Testing Services – Independent – Hospital based	 $25 copay per visit $50 copay per visit
OP High Tech Radiology Independent and Hospital Based (e.g. MRI, MRA, CT, PET scan)	$150 copay per visit
Chiropractic (up to 30 visits per Plan Year)	Covered at 75%
Physical & Occupational Therapy (30 visits combined per Plan Year)	$25 copay per visit
Speech Therapy (30 visits per Plan Year)	$25 copay per visit
Radiation Therapy and Chemotherapy	$25 copay per visit
Inpatient Hospital – Semiprivate Room (including intensive care, if medically necessary) – Physician's & Surgeon's Services – Other Medical Professional Services (including maternity)	 $250 copay per day for first 5 days per Plan Year. Maximum copay: $1250/individual, $2500/family Covered at 100% Covered at 100%
Outpatient Surgical Facility – Outpatient Ambulatory – Outpatient Hospital	 Covered at 100% $100 copay per visit

BLUE CARE® IPA $15/$25 100 CONTINUED

EMERGENCY SERVICES	IN NETWORK BENEFITS
Emergency Room	$100 copay per visit, waived if admitted
Urgent Care Centers / Medical Aid Units	$25 copay per visit
Ambulance	$50 copay per visit
OTHER SERVICES	**IN NETWORK BENEFITS**
Inpatient Private Duty Nursing (up to 240 hours per 12 month period)	Covered at 100%
Durable Medical Equipment (DME)	Covered at 75%
Skilled Nursing Facility (up to 120 days per confinement)	Covered at 100%
Home Health Care (up to 100 visits per Plan Year)	Covered at 100%
Alcohol and Substance Abuse Treatment[1]	Covered same as medical
Serious Mental Health Care[1]	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 60%
– Outpatient (up to 20 visits per Plan Year)	$25 copay per visit
PRESCRIPTION DRUGS	
Prescription Drugs	See "Your Prescription Drug Program"

[1]Delaware law defines serious mental illness as including nine diagnostic classes. Benefits for serious mental illness and substance abuse treatment are covered at the same levels as other medical care.

Your PCP must authorize your health care services. Most medical services are provided in the offices of panel physicians. Note: 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 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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