BlueCross BlueShield of Delaware

HIPAA Benefits Summary

BENEFITS	SIMPLYBLUE EPO $20/$2000/$6000	BLUE ADVANTAGE PPO (HSA® compatible) $1800	
		In Network	Out of Network
Calendar Year Deductible	$2,000 individual; $6,000 family*	$1,800 individual; $3,600 family*	$1,800 individual; $3,600 family*
Calendar Year Coinsurance Expense Limit	$3,000 individual; $4,000 family	None	$3,450 individual; $6,900 family
HOSPITAL AND OTHER FACILITY BENEFITS			
Inpatient days including, serious mental illness and substance abuse admissions	80% covered after the deductible	100% covered after the deductible	80% covered after the deductible**
Outpatient Surgical Facility	80% covered after the deductible	100% covered after the deductible	80% covered after the deductible
Outpatient Emergency Facility	$150 copay per visit after the deductible	100% covered after the deductible	80% covered after the deductible
MEDICAL-SURGICAL BENEFITS			
Outpatient Physician Visit	PCP: $20 copy per visit (no deductible) Specialist: $45 copay per visit after the deductible	100% covered after the deductible	80% covered after the deductible
Inpatient: medical, surgical, anesthesia, serious mental illness, and substance abuse services	80% covered after the deductible	100% covered after the deductible	80% covered after the deductible**
Outpatient: medical, surgical, anesthesia, serious mental illness, and substance abuse services	80% covered after the deductible	100% covered after the deductible	80% covered after the deductible; out of network substance abuse services not covered
Lab	Non Hospital Based: $10 copay per visit Hospital Based: 80% covered after the deductible	100% covered after the deductible	80% covered after the deductible
Imaging and Machine Testing	Non Hospital Based: $20 copay per visit Hospital Based: 80% covered after the deductible	100% covered after the deductible	80% covered after the deductible
High Tech Radiology (Hospital and Non Hospital Based)	80% covered after the deductible	100% covered after the deductible	80% covered after the deductible
Physical and Occupational Therapy 30 visits combined per calendar year	$45 copay after the deductible	100% covered after the deductible	80% covered after the deductible
Chemotherapy and Radiation Therapy	$45 copay after the deductible	100% covered after the deductible	80% covered after the deductible
PREVENTIVE CARE			
Physical Exams	100% covered	100% covered	Not covered
Mammograms	100% covered	100% covered	80% covered
Well-Child Care	100% covered	100% covered	Not covered
Immunizations	100% covered	100% covered	80% covered
Vision Exams	100% covered	100% covered	Not covered
Routine Pap Smear, Blood Antigen Testing Lab Charges	100% covered	100% covered	80% covered

(continued on reverse)

BENEFITS	SIMPLY BLUE EPO $20 $2000/$6,000	BLUE ADVANTAGE PPO (HSA® compatible) $1800	
		In Network	Out of Network
PREVENTIVE CARE continued			
Routine Gynecological Exam	100% covered	100% covered	Not covered
PRESCRIPTION DRUGS	Your prescription drug benefits have a contract year deductible that is separate from the health care calendar deductible. Copayments you pay for prescription drugs are not applied to the drug deductible. Prescription Drug copays and coinsurance are not applied to the health care plan deductible or coinsurance limit. Calendar Year Deductible: $500 per person. Generic drugs are not subject to the deductible. Generic $15 copay 34-day supply; $30 copay 35-90 day supply. Preferred brand covered 75% after the deductible. Non-Preferred brand covered 50% after deductible.	100% covered after the deductible	100% covered after the deductible
MENTAL HEALTH BENEFITS (For approved non-serious mental health care)			
Inpatient Facility and Physician 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.	80% covered after the deductible	100% covered after the deductible	80% covered after the deductible
Outpatient Services (up to 20 visits per calendar year)	$45 per visit after the deductible	100% covered after the deductible	80% covered after the deductible
	No coverage for maternity or bariatric surgery	No coverage for maternity or bariatric surgery **Out of Network inpatient and intensive outpatient care limited to one 270 day period per lifetime, 31 day limit on inpatient, 62 day limit on intensive outpatient; days offset 1 for 2 and vice versa	

- All calculations of your deductible and coinsurance amounts, and our benefit payments, are based on Blue Cross Blue Shield of Delaware allowable charges.
- Persons who are eligible to apply for Individual HIPAA contracts due to prior continuous creditable coverage of at least 18 months, and who have no more than a 63 day break in coverage between the prior coverage and the HIPAA coverage, will not have to satisfy a preexisting condition waiting period under the Individual HIPAA contract.
- The plan includes preferred coverage for organ transplants performed at the Blue Distinction Centers for Transplants (BDCT). For transplants performed at participating but non0BDCT facilities, charges are covered at a reduced benefit level. Transplants performed at non-participating facilities are not covered.

*Coverage elected for more than one person is family coverage. One or more family members must satisfy the entire family deductible in any combination before benefits will pay.

This benefits summary presents plan highlights only. It is not a contract. If you have any questions or need more information, please contact us toll-free at 1.888.692.5830.