HIGHMARK. Delaware

Blue Individual EPO $30 $1,200/$2,400

Plan Year Deductibles

Individual	$1,200
Family	$2,400

Plan Year Coinsurance Limit : Individual/Family $1,000/$2,000

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	$30 copay per visit
• Specialist/Referral Care	$40 copay per visit
• Laboratory Services	
o Independent	$30 copay per visit
o Hospital based	Covered at 80%[1]
• Imaging & Machine Testing Services	
o Independent	$30 copay per visit
o Hospital based	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	
o Semiprivate Room (including intensive care, if medically necessary)	Covered at 80%[1]
o Physician's & Surgeon's Services	Covered at 80%[1]
o Other Medical Professional Services	Covered at 80%[1]
• Maternity (hospital, birthing center and pre-natal and post-natal care)	Not covered
• Outpatient Surgical Facility	
o Outpatient Ambulatory	Covered at 80%[1]
o Outpatient Hospital	Covered at 80%[1]

Emergency Services	In Network Benefits
• Emergency Room	$250 copay (waived if admitted)
• Urgent Care Centers / Medical Aid Units	$40 copay
• 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 80%[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 o 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. o Outpatient (up to 20 visits per Plan Year)	Covered at 80%[1] $40 Copay per visit

Prescription Drugs

• Your prescription drug benefits have a contract year deductible that is separate from the health care plan deductible. Copayments for prescription drugs are not applied to the contract year prescription drug deductible. Prescription drug copays and coinsurance are not applied to the health care plan deductible or coinsurance expense limit.

Generic drugs are not subject to the contract year prescription drug deductible
Per Prescription or Refill: UP TO A 90-DAY SUPPLY
• Generic $15 Copay 34-DAY SUPPLY; $30 copay 35-90 DAY SUPPLY

Contract year prescription drug deductible: $500 per person
• Preferred Brand covered $40 after deductible 34-DAY SUPPLY; $80 copay after deductible 35-90 DAY SUPPLY
• Non-Preferred Brand covered $80 after deductible 34-DAY SUPPLY; $160 copay after deductible 35-90 DAY SUPPLY
If an individual chooses a Preferred or Non-Preferred Brand drug when a Generic drug is available, he or she will have to pay the difference between the charge for the Preferred or Non-Preferred Brand drug and the Generic drug, plus the copay for the Generic Drug

1 Benefits are subject to a Plan Year deductible of $1,200 per person ($2,400 per family). Two individuals must meet the individual deductible for the family deductible to be met.

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.

Note: Applicable copays still apply after coinsurance expense limit has been reached. Blue Individual plans do not cover maternity services or bariatric surgery.

The plan includes 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 PPO providers anywhere in the nation. If you are enrolling in the EPO plan, you can take advantage of additional resources. The Blue Cross and Blue Shield Association's web site, **bluecares.com**, provides online access to the most current listing of providers, whether you need covered medical care close to home, across the country or around the world. On the bluecares.com home page, EPO enrollees should click on BlueCard® Doctor and Hospital Finder, provide the information requested, an choose the PPO Network option. Once you submit your information, you'll instantly receive an online list of network providers in the zip code requested—as well as driving directions to their offices or facilities. If you prefer personal help by phone, you can find network providers by calling a BlueCard customer service representative at **1-800-810-BLUE (2583)**.

This benefit outline presents plan highlights only. It is not a contract, and it is not a Summary of Benefits and Coverage (SBC) as required by federal law. You can obtain an SBC by visiting www.highmarkbcbsde.com or calling 1-800-633-2563.