

# Summary of Shared Cost PPO \$2600/70 Benefits

On the chart below, you'll see what your plan pays for specific services.

Benefit	In-Network	Out-of-Network
<b>General Provisions</b>		
<b>Benefit Period</b> (1)	Contract Year	
<b>Deductible</b> (per benefit period)(2)		
Individual	\$2,600	\$5,200
Family	\$5,200	\$10,400
<b>Plan Pays (unless otherwise specified)</b> – payment based on the plan allowance	70% after deductible	50% after deductible
<b>Out-of-Pocket Limit</b> (Includes deductible, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period.)		
Individual	\$8,550	\$17,100
Family - Aggregate	\$17,100	\$34,200
<b>Office/Clinic/Urgent Care Visits</b>		
<b>Primary Care Provider Office Visits</b>	100% after \$55 copay	50% after deductible
<b>Virtual Primary Care Program</b>	100%	Not Covered
<b>Specialist Office Visits</b>	100% after \$80 copay	50% after deductible
<b>Urgent Care Center Visits</b>	100% after \$90 copay	50% after deductible
<b>Telemedicine Service</b> (3)	100% after \$20 copay	Not Covered
<b>Preventive Care</b> (4)		
<b>Routine Adult</b>		
Adult immunizations	100%	50% after deductible
Colorectal cancer screening	100%	50% after deductible
Diagnostic services and procedures	100%	50% after deductible
Routine mammograms	100%	50% after deductible
Physical exams	100%	50% after deductible
Routine gynecological exams, including a Pap test	100%	50% after deductible
Routine adult vision exam - Health Care Reform Vision Network (8)	Not Covered	Not Covered
<b>Routine Pediatric</b>		
Pediatric immunizations	100%	50% after deductible
Physical exams	100%	50% after deductible
<b>Pediatric Vision</b> (5) - <b>Health Care Reform Vision Network (8)</b>		
Exam (including dilation, as professionally indicated)	100%	Not Covered
Pediatric frame selection	100%	Not Covered
Standard eyeglass lenses (per pair)	100%	Not Covered
<b>Pediatric Dental</b> (5) - <b>United Concordia Advantage Plus 2.0 Network</b>		
Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants)	100%	Not Covered
Basic Services (amalgam restorations (metal fillings), resin based composite fillings (white fillings))	50%	Not Covered
Major Services (crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.))	50%	Not Covered
Orthodontics(6) (Medically necessary with prior approval)	50%	Not Covered
<b>Hospital and Medical/Surgical Expenses (including maternity)</b>		
<b>Anesthesia</b>	70% after deductible	
<b>Hospital Inpatient</b> (7) (professional & facility)	70% after deductible	50% after deductible
<b>Hospital Outpatient</b> (7) (Non-Surgical)	70% after deductible	50% after deductible
<b>Outpatient Surgery</b> (7) (9)	100% after deductible and \$200 copay	50% after deductible
<b>Maternity</b> (7) (non-preventive facility & professional services) including dependent daughter	70% after deductible	50% after deductible
<b>Medical Care</b> (including inpatient visits and consultations) <b>/Surgical Expenses</b>	70% after deductible	50% after deductible
<b>Emergency Services</b>		
<b>Emergency Room Services</b>	100% after \$625 copay (waived if admitted)	
<b>Ambulance</b> (11)	70% after in-network deductible	
<b>Therapy, Rehabilitative and Habilitative Services</b>		
<b>Chiropractic</b>	75% after deductible	75% after deductible
	Limit: 30 visits/benefit period SB#225 services related to the treatment of back pain are excluded from visit limits	
<b>Cardiac Rehab</b>	70% after deductible	50% after deductible
	Limited to 3 sessions per week and 12 weeks of treatment. Care beyond this limit requires medical review and approval.	
<b>Chemotherapy and Radiation Therapy</b>	70% after deductible	50% after deductible
	100% after \$15 copay	75% after deductible
<b>Physical &amp; Occupational Therapy (combined)</b> (Rehabilitative and Habilitative)	Limit: 30 Rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to Habilitative services for the treatment of a Mental Health or Substance Abuse diagnosis SB#225 services related to the treatment of back pain are excluded from visit limits	
<b>Respiratory Therapy</b>	70% after deductible	50% after deductible

Benefit	In-Network	Out-of-Network
<b>Speech Therapy</b> (Rehabilitative and Habilitative)	100% after \$80 copay Limit: 30 Rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to Habilitative services for the treatment of a Mental Health or Substance Abuse diagnosis	50% after deductible
<b>Mental Health/Substance Abuse</b>		
<b>Inpatient(7)</b> (professional & facility)	70% after deductible	50% after deductible
<b>Inpatient Detoxification/Rehabilitation(7)</b>	70% after deductible	50% after deductible
<b>Outpatient(7)</b> (professional & facility)	100% after \$55 copay	50% after deductible
<b>Other Services</b>		
<b>Diagnostic Services</b>		
<i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	100% after \$570 copay	50% after deductible
<i>Diagnostic X-ray</i>	100% after \$85 copay	50% after deductible
<i>Laboratory</i>	100% after \$85 copay	50% after deductible
<b>Durable Medical Equipment</b>	70% after deductible	50% after deductible
<b>Orthotics and Prosthetics</b>	70% after deductible	50% after deductible
<b>Home Health Care</b>	70% after deductible	50% after deductible
<b>Hospice</b>	70% after deductible	50% after deductible
<b>Private Duty Nursing</b>	70% after deductible	50% after deductible
<b>Skilled Nursing Facility Care(7)</b>	70% after deductible Limit: Inpatient only - 240 hours per benefit period	50% after deductible
<b>Transplant Services</b>	70% after deductible	50% after deductible
<b>Onduo Diabetic Management Program</b>	100%	Not Covered
<b>Prescription Drugs</b>		
<b>Prescription Drug Program</b> (10) Mandatory Generic <i>Defined by the National Plus Pharmacy Network. Prescriptions filled at a non-network pharmacy are not covered.</i>  <i>Your plan uses the HCR Comprehensive Formulary with an Incentive Benefit Design.</i>	<b>34-Day Supply/Up to a 90-Day Supply</b> \$3 low cost generic copay -- \$40 standard generic copay (Up to 90 day supply) \$80 / \$160 formulary brand copay \$125 / \$250 non-formulary copay Cost-sharing for Prescription Insulin Drugs will not exceed \$100 for a month supply	

- 1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
- 2) When calculating the deductible expenses, only the allowable charges are considered.
- 3) Services must be performed by a Highmark approved telemedicine provider.
- 4) Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
- 5) Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.
- 6) A Medically Necessary orthodontic service is an orthodontic procedure that occurs as part of an approved orthodontic plan that is intended to treat a severe dentofacial abnormality. Prior approval is required. See your benefit booklet for more details.
- 7) Precertification or preauthorization requirements may apply to certain inpatient admissions, outpatient procedures, or covered services (including covered medications).
- 8) Members must use a Davis provider who participates in the Health Care Reform Vision Network
- 9) Refers to outpatient surgical procedure provided in a hospital or ambulatory facility setting.
- 10) You have a soft mandatory generic provision, where you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.
- 11) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield Delaware which is an independent licensee of the Blue Cross Blue Shield Association. Health care plans are subject to terms of the benefit agreement. To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to [DiscoverHighmark.com/QualityAssurance](http://DiscoverHighmark.com/QualityAssurance); or for a paper copy, call 1-855-873-4109.

**All percentages are based on Highmark Blue Cross Blue Shield Delaware's allowable charge. Plan limitations and exclusions apply.**

#### Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters

Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: [CivilRightsCoordinator@highmarkhealth.org](mailto:CivilRightsCoordinator@highmarkhealth.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S.

*This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.*  
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Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

**ATENCIÓN:** Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

**CHÚ Ý:** Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

**알림:** 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

**ATENSYON:** Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

**ВНИМАНИЕ:** Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبیه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

**Kominike :** Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

**ATTENTION:** Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

**UWAGA:** Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

**ATENÇÃO:** Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

**ATTENZIONE:** se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

**ACHTUNG:** Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.**

**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage [www.highmarkbcbsde.com](http://www.highmarkbcbsde.com) or call 1-800-633-2563. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.HealthCare.gov/sbc-glossary/](http://www.HealthCare.gov/sbc-glossary/) or call 1-800-633-2563 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$2,600 individual/\$5,200 family <u>network</u> , \$5,200 individual/\$10,400 family out-of- <u>network</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Network deductible</u> does not apply to office visits, <u>preventive care services</u> , <u>diagnostic tests</u> , imaging tests, <u>emergency room care</u> , <u>urgent care</u> , outpatient mental health, outpatient substance abuse, <u>rehabilitation services</u> , <u>habilitation services</u> , pediatric vision, pediatric dental, and <u>prescription drug</u> benefits.  <u>Copayments</u> and <u>coinsurance</u> amounts don't count toward the <u>network deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$8,550 individual/\$17,100 family <u>network</u> . \$17,100 individual/\$34,200 family out-of- <u>network</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , balance-billed charges, <u>prescription drug</u> expenses, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

An example of a benefit book can be found at <https://shop.highmark.com/sales/#!/sbc-agreements>.

<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. For a list of <u>network providers</u> , see <a href="https://www.highmarkbcbsde.com/find-a-doctor/">https://www.highmarkbcbsde.com/find-a-doctor/</a> or call 1-800-633-2563.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do I need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$55 <u>copay</u> /visit <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.  Please refer to your <u>preventive</u> schedule for additional information.
	<u>Specialist</u> visit	\$80 <u>copay</u> /visit <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	
	<u>Preventive care/ screening/immunization</u>	No charge <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	\$85 <u>copay</u> /visit <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	\$570 <u>copay</u> /visit <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="https://www.highmarkbcbsde.com/find-a-doctor#/drug">https://www.highmarkbcbsde.com/find-a-doctor#/drug</a>	Low Cost Generic drugs	\$3/\$3 <u>copay</u> /prescription (retail) \$3/\$3 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	Up to a 34/90 - day supply retail pharmacy.  Up to a 34/90 - day supply maintenance <u>prescription drugs</u> through mail order.  This <u>plan</u> has an HCR Comprehensive <u>Formulary</u> .  <u>Cost-sharing</u> for Prescription Insulin Drugs will not exceed \$100 per month.
	Generic drugs	\$40/\$40 <u>copay</u> /prescription (retail) \$40/\$40 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
	<u>Formulary</u> Brand drugs	\$80/\$160 <u>copay</u> /prescription (retail) \$80/\$160 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply	Not covered	
	Non- <u>Formulary</u> Brand drugs	\$125/\$250 <u>copay</u> /prescription (retail) \$125/\$250 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$200 <u>copay</u> /visit	50% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$625 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$625 <u>copay/visit</u> <u>Deductible</u> does not apply.	<u>Copay</u> waived if admitted as an inpatient.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Out-of-network: Subject to <u>network deductible</u> .
	<u>Urgent care</u>	\$90 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
If you have mental health, behavioral health, or substance abuse services	Outpatient services	\$55 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Precertification may be required.
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
If you are pregnant	Office visits	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Network</u> : The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health <u>Preventive Schedule</u> for additional information. Precertification may be required.
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : 100 visits per benefit period aggregate with visiting nurse. Precertification may be required.
	<u>Rehabilitation services</u>	\$15 <u>copay</u> /visit (physical and occupational therapy) \$80 <u>copay</u> /visit (speech therapy) <u>Deductible</u> does not apply.	25% <u>coinsurance</u> (physical and occupational therapy) 50% <u>coinsurance</u> (speech therapy)	Combined <u>network</u> and out-of- <u>network</u> : 30 combined physical medicine and occupational therapy visits per benefit period; limitation does not apply for the diagnosis of back pain. 30 speech therapy visits per benefit period. Precertification may be required
	<u>Habilitation services</u>	\$15 <u>copay</u> /visit (physical and occupational therapy) \$80 <u>copay</u> /visit (speech therapy) <u>Deductible</u> does not apply.	25% <u>coinsurance</u> (physical and occupational therapy) 50% <u>coinsurance</u> (speech therapy)	Combined <u>network</u> and out-of- <u>network</u> : 30 combined physical medicine and occupational therapy visits per benefit period; limitation does not apply for the diagnosis of mental health, substance abuse, or back pain. 30 speech therapy visits per benefit period. Precertification may be required
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : 120 days per confinement. Benefits renew after 180 days without care. Precertification may be required.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	No charge <u>Deductible</u> does not apply.	Not covered	<u>Network</u> : One eye exam per 12 month period up to age 19.
	Children's glasses	No charge <u>Deductible</u> does not apply.	Not covered	<u>Network</u> : One pair frames/lenses every 12 months.
	Children's dental check-up	No charge <u>Deductible</u> does not apply.	Not covered	<u>Network</u> : One exam every 6 months.



## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Long-term care
- Routine foot care
- Cosmetic surgery
- Routine eye care (Adult)
- Weight loss programs
- Dental care (Adult)

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Infertility treatment
- Private-duty nursing
- Chiropractic care
- Non-emergency care when traveling outside the U.S. See <http://www.bcbsa.com>
- Hearing aids

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or at [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <http://www.HealthCare.gov> or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Highmark Delaware at 1-800-633-2563.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

### Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$2,600
- Specialist copayment \$80
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

**This EXAMPLE event includes services like:**

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

**Total Example Cost** \$12,700

**In this example, Peg would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,600
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$2,500

***What isn't covered***

Limits or exclusions	\$60
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**The total Peg would pay is \$5,960**

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$2,600
- Specialist copayment \$80
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

**This EXAMPLE event includes services like:**

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

**Total Example Cost** \$5,600

**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$800
<u>Copayments</u>	\$1,800
<u>Coinsurance</u>	\$0

***What isn't covered***

Limits or exclusions	\$20
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**The total Joe would pay is \$2,620**

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$2,600
- Specialist copayment \$80
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

**This EXAMPLE event includes services like:**

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

**Total Example Cost** \$2,800

**In this example, Mia would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,200
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0

***What isn't covered***

Limits or exclusions	\$0
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**The total Mia would pay is \$2,000**

The plan would be responsible for the other costs of these EXAMPLE covered services.