Summary of Shared Cost PPO $1000/100 *Benefits*

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

Benefit	In-Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period)(2) Individual Family	$1,000 $2,000	$2,000 $4,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes deductible, coinsurance and copayments. Once met, plan pays 100% coinsurance for the rest of the benefit period.) Individual Family - Aggregate	$9,100 $18,200	$18,200 $36,400
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	$25 copay	20% after deductible
Primary Care Provider Office Visits and Virtual Visits	Office Visit: $25 copay Virtual Visit: $0 copay	20% after deductible
Virtual Primary Care Program	$0	Not Covered
Specialist Office Visits/Virtual Visits	$60 copay	20% after deductible
Urgent Care Center Visits	$60 copay, the copayment, if any, does not apply to urgent care services prescribed for the treatment of mental illness or substance abuse	20% after deductible
Preventive Care(3)		
Routine Adult		
Adult immunizations	$0	20% after deductible
Colorectal cancer screening	$0	20% after deductible
Diagnostic services and procedures	$0	20% after deductible
Breast cancer screenings (annual routine and supplemental)	$0	Not Covered
Ovarian Cancer Screening Tests (two annually)	$0, deductible does not apply	Not Covered
Physical exams	$0	20% after deductible
Routine gynecological exams, including a Pap test	$0	20% after deductible
Routine adult vision exam **-** Health Care Reform Vision Network (7)	Not Covered	Not Covered
Routine Pediatric		
Pediatric immunizations	$0	20% after deductible
Physical exams	$0	20% after deductible
Pediatric Vision(4) **- Health Care Reform Vision Network (7)**		
Exam (including dilation, as professionally indicated)	$0	Not Covered
Pediatric frame selection	$0	Not Covered
Standard eyeglass lenses (per pair)	$0	Not Covered
Pediatric Dental(4) **- United Concordia Advantage Plus 2.0 Network**		
Preventive Services (Exam, Cleanings, Radiographs (all x-rays), Fluoride treatments, sealants)	$0	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(5) (Medically necessary with prior approval)	50%	Not Covered
Hospital and Medical/Surgical Expenses (including maternity) (11)		
Anesthesia	$0 after in-network deductible	
Hospital Inpatient (6) (facility & professional)	$0 after deductible	20% after deductible
Hospital Outpatient (6)(8) (ASC professional)	$0 after deductible	20% after deductible
Hospital Outpatient (6)(8) (ASC facility)	$175 copay after deductible	20% after deductible
Maternity(6) (non-preventive facility & professional services) including dependent daughter	$0 after deductible	20% after deductible
Medical Care (including inpatient visits and consultations)**/Surgical Expenses**	$0 after deductible	20% after deductible
Emergency Services		
Emergency Room Services (Facility Fee) (10)	$300 copay (copay waived if admitted to the hospital)	
Emergency Room Services (Professional Fee) (10)	$0 after deductible	
Ambulance (11)	$0 after in-network deductible	
Therapy, Rehabilitative and Habilitative Services		
Chiropractic	$0 after deductible	20% after deductible
	Limit: 30 visits/benefit period - limit does not apply to the treatment of back pain	
Cardiac Rehab	$0 after deductible	20% after deductible
	Limited to 3 sessions per week and 12 weeks of treatment. Care beyond this limit requires medical review and approval.	
Chemotherapy and Radiation Therapy	$0 after deductible	20% after deductible
	$20 copay	20% after deductible

Benefit	In-Network	Out-of-Network
Physical & Occupational Therapy (combined) (Rehabilitative and Habilitative)	Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to the treatment of back pain by chiropractors or physical therapists or to therapy services for the treatment of a Mental Health or Substance Abuse diagnosis	
Respiratory Therapy	$0 after deductible	20% after deductible
Speech Therapy (Rehabilitative and Habilitative)	$60 copay	20% after deductible
	Limit: 30 rehabilitative and 30 Habilitative visits /benefit period - Limit does not apply to therapy services for the treatment of a Mental Health or Substance Abuse diagnosis The copayment, if any, does not apply to speech therapy services prescribed for the treatment of mental illness or substance abuse.	
Applied Behavior Analysis for Autism Spectrum Disorders (ASD) (Treatment for autism spectrum disorders does not reduce visit/day limits for other therapy benefits.)	ABA services do not apply copay, but service level deductible and/or coinsurance amounts do apply.	
Mental Health/Substance Abuse		
Inpatient(6) (professional & facility)	$0 after deductible	20% after deductible
Inpatient Detoxification/Rehabilitation(6)	$0 after deductible	20% after deductible
Outpatient(6) (professional & facility)	Office Visit: $25 copay Virtual Visit: $0 copay	20% after deductible
Other Services		
Diabetes Care Management Program (Digitally Monitored)	$0 Deductible, if any does not apply	Not Covered
	Continuous glucose monitor sprints are limited to three (3) per benefit period for members diagnosed with type 2 diabetes	
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	$250 copay, the copayment, if any, does not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse	20% after deductible
Diagnostic X-ray	$35 copay, the copayment, if any, does not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse	20% after deductible
Laboratory	$25 copay, the copayment, if any, does not apply to diagnostic services prescribed for the treatment of mental illness or substance abuse	20% after deductible
Diagnostic Breast Examination (annual mammogram, MRI, ultrasound)	$0, deductible if any does not apply	20% after deductible
Ovarian Cancer Monitoring Tests (two annually)	$0, deductible does not apply	20% after deductible
Durable Medical Equipment	$0 after deductible	20% after deductible
	The deductible and cost sharing amount, if any, does not apply to insulin pumps. The deductible and member cost-sharing amount, if any, will not exceed $35 per month for the following diabetes equipment and supplies purchased through in-network providers: covered blood glucose meters and strips, urine testing strips, syringes, continuous glucose monitors and supplies, and insulin pump supplies.	
Orthotics and Prosthetics	$0 after deductible	20% after deductible
Home Health Care	$0 after deductible	20% after deductible
	Limit: 100 visits/benefit period Aggregate with Visiting Nurse	
Hospice	$0 after deductible	20% after deductible
Private Duty Nursing	$0 after deductible	20% after deductible
	Limit: Inpatient only - 240 hours per benefit period	
Skilled Nursing Facility Care(6)	$0 after deductible	20% after deductible
	Limit: 120 days per confinement - benefits renew after 180 days without care	
Transplant Services	$0 after deductible	20% after deductible
Prescription Drugs		
Prescription Drug Program (9)(10) Soft Mandatory Generic *Defined by the National Plus Pharmacy Network, not the physician network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the HCR Comprehensive Formulary with an Incentive Benefit Design.*	**34-Day Supply/Up to a 90-Day Supply** $3 low cost generic copay -- $30 standard generic copay (Up to 90 day supply) $70 / $140 formulary brand copay $120 / $240 non-formulary copay Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a month supply; satisfaction of the deductible, if any, is not required. The deductible and member cost-sharing amount, if any, will not exceed $35 per month for the following diabetes equipment and supplies purchased through in-network providers: covered blood glucose meters and strips, urine testing strips, syringes, continuous glucose monitors and supplies, and insulin pump supplies.	

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 are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Age and frequency limits may apply.
4) Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19. All dental services must be provided by a United Concordia Advantage Plus 2.0 Network Provider, except as otherwise described in the booklet.
5) 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.
6) Precertification or preauthorization requirements may apply to certain inpatient admissions, outpatient procedures, or covered services (including covered medications).

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.

7) Members must use a Davis provider who participates in the Health Care Reform Vision Network
8) Refers to outpatient surgical procedure provided in a hospital or ambulatory facility setting.
9) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety, and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, 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.
10) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the in-network level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the in-network level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan's allowable charge for such services.
11) Benefits for Ambulance Services provided by air and rendered by an Out-of-Network provider and/or Emergency Ambulance Services rendered by an Out-of-Network Provider, will be paid at the in-network level and will be subject to the deductible amount, if any, that is applicable to in-network services. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan's allowable charge for such services. When Emergency Ambulance Services are provided by ground or water, the member may be responsible for any amounts billed by out-of-network volunteer fire companies or emergency medical services provider agencies certified by the Delaware State Fire Prevention Commission that are in excess of the plan's allowable charge for such services.

Insurance or benefit administration may be provided by Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield ("Highmark") which serves the state of Delaware and 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 https://www.highmark.com/content/dam/digital-marketing/en/highmark/highmarkdotcom/pdfs/quality-assurance/CS204330_NCQAPreSale_BRO_DE_R2.pdf; or for a paper copy, call 1-855-873-4109.

All percentages are based on Highmark'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. 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. 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).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة 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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