# *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)<br>Individual<br>Family | <br>$1,000<br>$2,000 | <br>$2,000<br>$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.)<br>Individual<br>Family - Aggregate | <br>$10,600<br>$21,200 | <br>$21,200<br>$42,400 |
| **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 |
| **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) | $150 copay after deductible, per admission | 20% after deductible |
| **Hospital Outpatient (6)(8)** (ASC professional) | $0 after deductible | 20% after deductible |
| **Hospital Outpatient (6)(8) (**ASC facility) | $250 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) | $400 copay (copay waived if admitted to the hospital) | |
| **Emergency Room Services (Professional Fee)** (10) | $0 | |
| **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 |
| **Physical & Occupational Therapy (combined)** (Rehabilitative and Habilitative) | $20 copay | 20% after deductible |
| | Limit: 30 rehabilitative and 30 Habilitative visits /benefit period | |
| **Respiratory Therapy** | $0 after deductible | 20% after deductible |

| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Speech Therapy (Rehabilitative and Habilitative)** | $60 copay | 20% after deductible |
| | Limit: 30 rehabilitative and 30 Habilitative visits /benefit period | |
| **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) | $150 copay after deductible, per admission after deductible | 20% after deductible |
| **Inpatient Detoxification/Rehabilitation(6)** | $150 copay after deductible, per admission after deductible | 20% after deductible |
| **Outpatient(6)** (professional & facility) | Office Visit: $25 copay Virtual Visit: $0 copay | 20% after deductible |
| **Other Services** | | |
| **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* | $70 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* | $50 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 |
| | Insulin pumps are covered at 100%<br><br>The member cost-sharing amount for the following diabetes equipment and supplies purchased through in-network providers will not exceed $35 per month: 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)<br>Sensible Rx Complete<br>*Defined by the National Plus Pharmacy Network, not the physician network. Prescriptions filled at a non-network pharmacy are not covered.*<br><br>*Your plan uses the HCR Comprehensive Formulary with an Incentive Benefit Design.* | **34-Day Supply/Up to a 90-Day Supply**<br>$3 low cost generic copay -- $30 standard generic copay (Up to 90 day supply)<br>$85 / $170 formulary brand copay<br>$120 / $240 non-formulary copay<br>Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a month supply; satisfaction of the deductible, if any, is not required.<br><br>The member cost-sharing amount for the following diabetes equipment and supplies purchased through in-network providers will not exceed $35 per month: 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).

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 Sensible Rx Complete 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**

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- 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.

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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）。

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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.

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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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