HIGHMARK. Delaware

Summary of Health Savings EPO HSA $1500-100 C *Benefits*

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA).

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

Benefit	In-Network
General Provisions	
Benefit Period(1)	Contract Year
Deductible(2) (per benefit period) Individual Family	 $1,500 $3,000
Plan Pays (unless otherwise specified) – payment based on the plan allowance	100% after deductible
Out-of-Pocket Maximums (Includes deductible, coinsurance and copayments. Once met, plan pays 100% for the rest of the benefit period.) Employee Only Plan Family Plan	 $1,500 $3,000
Office/Clinic/Urgent Care Visits	
Primary Care Provider Office Visits	100% after deductible
Specialist Office Visits	100% after deductible
Urgent Care Center Visits	100% after deductible
Telemedicine Service(3)	100% after deductible
Preventive Care(4)	
Routine Adult Adult immunizations	 100% (deductible does not apply)
Colorectal cancer screening	100% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)
Routine mammograms	100% (deductible does not apply)
Physical exams	100% (deductible does not apply)
Routine gynecological exams, including a Pap test	100% (deductible does not apply)
Routine adult vision exam	100% (deductible does not apply)
Routine Pediatric Pediatric immunizations	 100% (deductible does not apply)
Physical exams	100% (deductible does not apply)
Pediatric Vision(5) Exam (including dilation, as professionally indicated)	 100% (deductible does not apply)
Pediatric frame selection	100% (deductible does not apply)
Standard eyeglass lenses (per pair)	100% (deductible does not apply)
Pediatric Dental(5) Exam and cleanings	 100% (deductible does not apply)
Basic Services (Fluoride treatments, sealants, consultations)	100% after deductible
Major Services (Radiographs (all x-rays), space maintainers, amalgam restorations (metal fillings), resin based composite fillings (white fillings), crowns, inlays, onlays, crown repair, endodontic therapy (root canals, etc.))	100% after deductible
Orthodontics(6) (Medically necessary with prior approval. Waiting limits apply.)	100% after deductible
Hospital and Medical/Surgical Expenses (including maternity)	
Anesthesia	100% after deductible
Hospital Inpatient(7) (professional & facility)	100% after deductible
Hospital Outpatient (professional & facility)	100% after deductible
Maternity(7) (non-preventive facility & professional services) including dependent daughter	100% after deductible
Medical Care (including inpatient visits and consultations)**/Surgical Expenses**	100% after deductible
Emergency Services	
Emergency Room Services	100% after deductible
Ambulance	Emergency: 100% after deductible
Therapy, Rehabilitative and Habilitative Services	

Benefit	In-Network
Chiropractic	100% after deductible Limit: 30 visits/benefit period
Cardiac Rehab	100% after deductible Limit: 3 sessions per week and 3 months of treatment
Chemotherapy and Radiation Therapy	100% after deductible
Respiratory Therapy	100% after deductible
Physical & Occupational Therapy (Rehabilitative and Habilitative)	100% after deductible Limit: 30 rehabilitative PT/OT combined visits/benefit period Limit: 30 habilitative PT/OT combined visits/benefit period
Speech (Rehabilitative and Habilitative)	100% after deductible Limit: 30 rehabilitative visits/benefit period Limit: 30 habilitative visits/benefit period
Mental Health/Substance Abuse	
Inpatient(7) (professional & facility)	100% after deductible
Inpatient Detoxification/Rehabilitation(7)	100% after deductible
Outpatient (professional & facility)	100% after deductible
Other Services	
Diagnostic Services	
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible
Diagnostic X-ray	100% after deductible
Laboratory	100% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible
Home Health Care	100% after deductible Limit: 100 visits per benefit period
Hospice	100% after deductible
Private Duty Nursing	100% after deductible Inpatient only - 240 hours per 12 month period
Skilled Nursing Facility Care	100% after deductible 120 days per confinement
Prescription Drugs	
Prescription Drug Program *Defined by the Premier Delaware Pharmacy Network.* *Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the HCR Comprehensive Formulary.*	**34-Day Supply/Up to a 90-Day Supply** 100% after deductible generic coinsurance 100% after deductible formulary brand coinsurance 100% after deductible non-formulary coinsurance

(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. If you select employee only coverage, the employee only deductible will apply. Benefits are then covered at the indicated percentage for each service until your out-of-pocket amount totals the employee out-of-pocket maximum. Benefits will then be paid at 100% of the allowable charge for you for the remainder of your Plan Year. If you select family coverage, the family deductible will apply. The entire family deductible must be satisfied before benefits will be paid for any family member. Once met, benefits are then covered at the indicated percentage for each service until the out-of-pocket costs total the family out-of-pocket maximum limit. Benefits will then be paid at 100% of the allowable charge for all family members for the remainder of the Plan Year.

(3) Services must be performed by a Highmark approved telemedicine provider.

(4) Services are limited to those listed on the Preventive Schedule.

(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. 12 month waiting period required. See your benefit booklet for more details.

(7) Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

Note:

There are no out-of-network benefits except for Emergency Services. You can find network providers anywhere in the nation through the BlueCard® provider finder on www.BCBS.com.

Some plans include reduced coverage for bariatric surgeries. Please check your benefit booklet (or contact your marketing representative to request a copy) for complete information.

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