

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.highmarkbcbsde.com](http://www.highmarkbcbsde.com) or by calling 1-844-459-6452.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-Network Medical: <b>\$4,500</b> person/ <b>\$9,000</b> family; In-Network Prescription Drug: <b>\$2,100</b> person/ <b>\$4,200</b> family. Out-of-network: No out-of-pocket limit.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance billing, health care this plan does not cover, bariatric surgery expenses and infertility expenses.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of in-network <u>providers</u> , see <a href="http://www.highmarkbcbsde.com">www.highmarkbcbsde.com</a> or call 1-844-459-6452.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay per visit	Not covered	Certain services require authorization.
	Specialist visit	\$25 copay per visit	Not covered	Certain services require authorization.
	Other practitioner office visit	20% coinsurance for Chiropractic Care	Not covered	Limited to 1 visit per day and 60 consecutive days per acute condition.
	Preventive care/screening/immunization	No charge	Not covered	Coverage is limited by age, gender and risk parameters as identified in Highmark Delaware's Preventive Health Guidelines. Refer to <a href="http://www.highmarkbcbsde.com">www.highmarkbcbsde.com</a> or call 1-844-459-6452 for specific information.
If you have a test	Diagnostic test (x-ray, blood work)	Laboratory: \$10 copay; X-ray: \$20 copay; Machine Testing: No Charge	Not covered	-- None --
	Imaging (CT/PET scans, MRIs)	No charge at freestanding facilities; \$35 copay per visit at hospital-based facilities	Not covered	Prior authorization required. Failure to pre-authorize will result in a denial.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
<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="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	\$8 copay for 30-day supply retail or mail order; \$16 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	Up to 30-day fills at retail or mail order for non-maintenance drugs; 90-day fills for maintenance drugs available at participating pharmacies or mail order only, maintenance drugs filled as 30-day supply incur penalty at fourth fill; under Choice Program, you pay applicable copay plus difference between generic and brand when generic equivalent is available. Erectile dysfunction (ED) drugs are not covered unless medically necessary for conditions other than ED. Prescription drugs with an over-the-counter equivalent are not covered.
	Preferred brand drugs	\$28 copay for 30-day supply retail or mail order; \$56 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	
	Non-preferred brand drugs	\$50 copay for 30-day supply retail or mail order; \$100 copay for 90-day supply participating retail or mail order	Reimbursement limited to in-network allowable amount minus applicable copay	
	Specialty drugs	Copay based on whether drug is generic, preferred, or non-preferred	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Outpatient Hospital: \$100 copay per visit; Ambulatory Surgery Center: \$50 copay per visit	Not covered	Certain services require authorization.
	Physician/surgeon fees	No charge	Not covered	Certain services require authorization.
<b>If you need immediate medical attention</b>	Emergency room services	\$150 copay per visit (waived if admitted)	\$150 copay per visit (waived if admitted)	Care must be rendered within 48 hours of onset of symptoms.
	Emergency medical transportation	\$50 copay per visit	Not covered	-- None --
	Urgent care	\$15 copay per visit	Not covered	-- None --

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# State of Delaware: Highmark IPA/HMO

Coverage Period: 07/01/2016 - 06/30/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 copay per day with maximum of \$200 per admission	Not covered	Pre-authorization required. Failure to preauthorize will result in a denial.
	Physician/surgeon fee	No charge	Not covered	Pre-authorization required. Failure to preauthorize will result in a denial.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$15 copay per visit	Not covered	-- None --
	Mental/Behavioral health inpatient services	\$100 copay per day with maximum of \$200 per admission	Not covered	Pre-authorization required. Failure to preauthorize will result in a denial.
	Substance use disorder outpatient services	\$15 copay per visit	Not covered	-- None --
	Substance use disorder inpatient services	\$100 copay per day with maximum of \$200 per admission	Not covered	Pre-authorization required. Failure to preauthorize will result in a denial.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	-- None --
	Delivery and all inpatient services	\$100 copay per day with maximum of \$200 per admission	Not covered	-- None --
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Coverage is limited to 240 visits per plan year. Pre-authorization required. Failure to pre-authorize will result in a denial.
	Rehabilitation services	20% coinsurance; no charge for applied behavioral analysis (ABA)	Not covered	Physical therapy is limited to 45 visits per medical condition. Occupational and speech therapies are covered for up to 60 consecutive days from the beginning of therapy per acute condition. ABA limited to \$36,000 per person per plan year to age 21.
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Skilled nursing care	No charge	Not covered	Coverage is limited to 120 days per benefit period. Benefits renew after 180 days without care. Pre-authorization required. Failure to pre-authorize will result in a denial.
	Durable medical equipment	20% coinsurance	Not covered	Certain services require authorization.
	Hospice service	No charge	Not covered	Coverage is limited to 365 days.
If your child needs dental or eye care	Eye exam	\$15 copay per visit	Not covered	Coverage is limited to 1 exam per 24 months.
	Glasses	Not covered	Not covered	You must pay 100% of these expenses.
	Dental check-up	No charge under Delta Dental or Dominion Dental	20% coinsurance under Delta Dental; not covered under Dominion Dental	Delta Dental: \$1,500 maximum per person per plan year; Dominion Dental: no maximum.

## Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Glasses</li> </ul>	<ul style="list-style-type: none"> <li>Habilitation services</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Chiropractic care</li> <li>Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids (up to age 24)</li> <li>Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> </ul>

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## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-844-459-6452. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [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).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Highmark Blue Cross Blue Shield Delaware at 1-844-459-6452 or [www.highmarkbcbsde.com](http://www.highmarkbcbsde.com). Additionally, a consumer assistance program can help you file an appeal. Contact The Delaware Department of Insurance/Consumer Assistance Program, 841 Silver Lake Blvd., Dover, DE 19904 or 302-674-7300 (local), 1-800-282-8611 (toll free) or [consumer@state.de.us](mailto:consumer@state.de.us).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-844-459-6452.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-459-6452.

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-459-6452.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-459-6452.

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

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,140
- Patient pays \$400

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$250
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$400</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,590
- Patient pays \$810

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$520
Coinsurance	\$250
Limits or exclusions	\$40
<b>Total</b>	<b>\$810</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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