HIGHMARK. Delaware

Peninsula Conference
Summary of Benefits HSA QHDHP PPO $1600 90%/70%

Benefit	In Network	Out-of-Network
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible- Non-embedded(2) – (per benefit period) Individual Family	 $1600 $4800	 $1600 $4800
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Coinsurance Maximum Non-embedded - (per benefit period) Individual Family	 $1000 $2000	 $1000 $2000
Total Maximum Out of Pocket- Non-embedded (includes medical deductible, coinsurance, copays, and prescription drug cost-sharing; Network only). Once met, plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $2600 $6800	 N/A N/A
Office/Clinic/Urgent Care Visits		
Primary Care Provider Office Visits	90% after deductible	70% after deductible
Specialist Office Visits	90% after deductible	70% after deductible
Urgent Care Center Visits	90% after deductible	70% after deductible
Telemedicine	90% after deductible	Not covered
Preventive Care(3)		
Routine Adult		
Physical exams	100% (deductible does not apply)	70% after deductible
Adult immunizations	100% (deductible does not apply)	70% after deductible
Colorectal cancer screening	100% (deductible does not apply)	70% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	70% after deductible
Routine Mammogram	100% (deductible does not apply)	70% after deductible
Prostate Specific Antigen Test	100% (deductible does not apply)	70% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	70% after deductible
Pediatric immunizations	100% (deductible does not apply)	70% after deductible
Vision Adult: Routine Vision Exam Pediatric Vision: Routine Vision Exam is included as part of the routine physical exam with the primary care physician	 100% (deductible does not apply) One routine eye exam every 24 months 100% (deductible does not apply) One routine eye exam every 12 months	 Not Covered Not Covered
Hospital and Medical/Surgical Expenses (including Maternity)		
Hospital Inpatient	90% after deductible	70% after deductible
Hospital Outpatient	90% after deductible	70% after deductible
Maternity (non-preventive facility & professional services)	90% after deductible	70% after deductible
Surgical Inpatient	90% after deductible	70% after deductible
Surgical Outpatient (except office visits)	90% after deductible	70% after deductible
Ambulatory Surgery	90% after deductible	70% after deductible
Anesthesia	90% after deductible	70% after deductible
Emergency Services		
Emergency Room Services	90% after deductible	
Ambulance	90% after deductible per occurrence	

Benefit	In Network	Out-of-Network
Outpatient Therapy Rehabilitation Services		
Physical and Occupational Therapy	90% after deductible	70% after deductible
	Limit: 30 visits/benefit period combined PT and OT; services related to the treatment of back pain are excluded from the visit limits	
Cognitive Therapy	90% after deductible	70% after deductible
Speech Therapy	90% after deductible	70% after deductible
	Limit: 30 visits per therapy/benefit period	
Chiropractic	90% after deductible	75% after deductible
	Limit: 30 visits/benefit period; services related to the treatment of back pain are excluded from the visit limits	
Cardiac Rehab	90% after deductible	70% after deductible
	Limit: 3 sessions a week and 3 months of treatment	
Chemotherapy and Radiation Therapy	90% after deductible	70% after deductible
Mental Health/Substance Abuse		
Inpatient	90% after deductible	70% after deductible
Inpatient Detoxification/Rehabilitation	90% after deductible	70% after deductible
Outpatient	90% after deductible	70% after deductible
Other Services		
Assisted Fertilization Procedures	Not Covered	
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
Standard Imaging (including diagnostic mammograms)	90% after deductible	70% after deductible
Laboratory	90% after deductible	70% after deductible
Durable Medical Equipment and Prosthetics	90% after deductible	70% after deductible
Home Health Care	90% after deductible	70% after deductible
	Limit: 100 visits/benefit period	
Hospice	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible	70% after deductible
	Limit: 240 hours/benefit period - Inpatient Only	
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	Limit: 120 days per confinement	
Transplant Services	90% after deductible This plan includes preferred coverage for organ transplant preformed at Blue Distinction Centers for Transplants (BDCT)	70% after deductible
Prescription Drugs		
Prescription Drug Program *Your plan uses the Comprehensive Formulary*	90% after deductible	Not Covered

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 deductible expenses, only the allowable charges are considered
3) Services are limited to those listed on the Highmark Delaware Preventive Schedule.

Non-Embedded:
If you are enrolled as an individual, the deductible, out-of-pocket maximum and Total Maximum Out-of-Pocket (TMOOP) for the "Employee Only" plan apply. If you are enrolled in a "Family" plan, the entire family deductible must be satisfied before any claim reimbursement begins. In addition the entire family out-of-pocket maximum must be satisfied for additional claim reimbursement. Once the entire family TMOOP is satisfied, claims will be reimbursed at 100% of the allowance for covered expenses for the family, regardless of whether the individual deductible, individual out-of-pocket maximum and individual TMOOP have been satisfied.

This is not a contract. This benefits summary presents plan highlights only. Contract limitations and exclusions apply.

Please refer to your benefits booklet (or contact your marketing representative to request a copy) for complete information.

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