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# *Peninsula Conference*

# *Summary of Benefits HSA QHDHP PPO $1600 90/70%*

| **Benefit** | **IN Network** | **Out-of-Network** |
| --- | --- | --- |
| **General Provisions** |
| **Benefit Period**(1) | Contract Year |
| **Deductible** – (per benefit period) (2) **Non-embedded**IndividualFamily  | $1600$4800 | $1600$4800 |
| **Plan Pays –** payment based on the plan allowance | 90% after deductible  | 70% after deductible |
| **Coinsurance Maximum -** (per benefit period) Non-embeddedIndividual Family  | $1000$2000 | $1000$2000 |
| **Total Maximum Out of Pocket (**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. Non-embeddedIndividualFamily | $2600$6800 | N/AN/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) |  Not Covered |
| Adult immunizations | 100% (deductible does not apply) | 70% after deductible |
| Colorectal cancer screening | 100% (deductible does not apply) |  70% after deductible |
| Routine gynecological exams,Pap Test | 100% (deductible does not apply) | Not Covered70% 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) |  Not Covered |
| 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 months100% (deductible does not apply)One routine eye exam every 12 months | Not CoveredNot 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 |
| **Outpatient Therapy Rehabilitation Services** |
| **Physical and Occupational Therapy** | 90% after deductible | 70% after deductible |
| Limit: 30 visits/benefit period combined PT and OT |
| **Cognitive Therapy** | 90% after deductible | 70% after deductible |
| **Outpatient Therapy Rehabilitation Services (Cont’d)** |
| **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 |
| **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.

**(2) 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.**

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