HIGHMARK. Delaware

Wesley College
Summary of Benefits EPO 100 $6,350/$12,700

.Benefit	IN Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible Aggregate (2) Individual Family	 $6,350 $12,700	 N/A N/A
Plan Pays – payment based on the plan allowance	100% after deductible	N/A
Total Maximum Out of Pocket (includes medical deductible, medical copays, and prescription cost-sharing- Network only). Once met, plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $6,350 $12,700	 N/A N/A
Office/Clinic/Urgent Care Visits		
Primary Care Provider Office Visits	100% after deductible	Not Covered
Specialist Office Visits	100% after deductible	Not Covered
Urgent Care Center Visits	100% 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)	Not Covered
Colorectal cancer screening	100% (deductible does not apply)	Not Covered
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	Not Covered
Routine Mammogram	100% (deductible does not apply)	Not Covered
Prostate Specific Antigen Test	100% (deductible does not apply)	
Routine Pediatric		
Physical exams	100% (deductible does not apply)	Not Covered
Pediatric immunizations	100% (deductible does not apply)	Not Covered
Vision Adult: Routine Vision Exam Pediatric Vision: Routine Vision Exam	 100% (deductible does not apply) One routine eye exam every 24 months 100% (deductible does not apply) Under 18 No Limitations	 Not Covered Not Covered
Hospital and Medical/Surgical Expenses (including Maternity)		
Hospital Inpatient	100% after deductible	Not Covered
Hospital Outpatient	100% after deductible	Not Covered
Maternity (non-preventive facility & professional services)	100% after deductible	Not Covered
Medical/Surgical (except office visits)	100% after deductible	Not Covered
Ambulatory Surgery	100% after deductible	Not Covered
Anesthesia	100% after deductible	
Emergency Services		
Emergency Room Services	100% after deductible	
Ambulance	100% after deductible	
Outpatient Therapy Rehabilitation Services		
Physical and Occupational Therapy	100% after deductible	Not Covered
	Limit: 30 visits/benefit period combined PT and OT	
Cognitive Therapy	100% after deductible	Not Covered
Speech Therapy	100% after deductible	Not Covered
	Limit: 30 visits per therapy/benefit period	
Chiropractic	100% after deductible	Not Covered
	Limit: 30 visits/benefit period	

.Benefit	IN Network	Out-of-Network
Cardiac Rehab	100% after deductible	Not Covered
	Limit: 3 sessions a week and 3 months of treatment	
Chemotherapy and Radiation Therapy	100% after deductible	Not Covered
Mental Health/Substance Abuse		
Inpatient	100% after deductible	Not Covered
Inpatient Detoxification/Rehabilitation	100% after deductible	Not Covered
Outpatient	100% after deductible	Not Covered
Other Services		
Assisted Fertilization Procedures	Not Covered	
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	Not Covered
Standard Imaging (including diagnostic mammograms)	100% after deductible	Not Covered
Laboratory	100% after deductible	Not Covered
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	Not Covered
Home Health Care	100% after deductible	Not Covered
	Limit: 100 visits/benefit period combined with visiting nurse	
Hospice	100% after deductible	Not Covered
Private Duty Nursing	100% after deductible	Not Covered
	Limit: 240 hours/benefit period Inpatient hospital or in a skilled nursing facility only	
Skilled Nursing Facility Care	100% after deductible	Not Covered
	Limit: 120 days/per confinement/ 180 day renewal	
Transplant Services	100% after deductible This plan includes preferred coverage for organ transplant preformed at Blue Distinction Centers for Transplants (BDCT). For transplants performed at participating but non-BDCT facilities, charges are covered at a reduced benefit level.	Not Covered
Prescription Drugs		
Prescription Drug Program *Per Prescription Per Refill*	34 Day Supply Generic $10 copay Preferred Brand $30 copay Non-Preferred Brand $60 copay 90 day supply Generic $20 copay Preferred Brand $60 copay Non-Preferred Brand $120 copay	Not Covered

There are no Out –of- Network benefits. EPO members can access In-Network PPO providers anywhere in the nation. The Blue Cross and Blue Shield Association's website, **bluecares.com**, provides online access to the most current listing of providers. EPO members can also find network providers by calling a BlueCard customer service representative **at 800-810-BLUE(2583).**

(1) Your group's benefit period is based on a Contract Year, a twelve month period beginning December 1, 2016.

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(2) When calculating deductible expenses, only the allowable charges are considered.

• If *family* coverage is elected, the family deductible will apply. The entire family deductible must be satisfied before benefits will be paid for any family member.

(3) Services are limited to those listed on the Highmark Delaware Preventive Schedule.

* Note: The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government effective with plan years beginning on or after January 1, 2014. Beginning January 1, 2015, TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense. TMOOP cannot be more than $6,600 for individual and $13,200 for two or more persons.

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.