

State of Delaware: Highmark First State Basic

Coverage for: Individual + Family | Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage you can visit www.highmarkbcbsde.com or call 1-844-459-6452. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.highmarkbcbsde.com or call 1-844-459-6452 to request a copy

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<u>Network provider</u> : \$500 individual/ \$1,000 family; <u>Out-of-Network provider</u> : \$1,000 individual/ \$2,000 family.	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Network</u> and <u>out-of-network Preventive care</u> and <u>network</u> and <u>out-of-network</u> freestanding emergency facility/urgent care center services are covered before you meet your <u>deductible</u> .	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this plan ?	<u>Network provider</u> Medical: \$2,000 individual/ \$4,000 family; <u>Network provider</u> Prescription Drug: \$2,100 individual/ \$4,200 family. <u>Out-of-Network provider</u> Medical: \$4,000 individual/ \$8,000 family; <u>Out-of-Network provider</u> Prescription Drug: Not Applicable.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance billing</u> charges, health care this plan does not cover, <u>coinsurance</u> on certain services and penalties for failure to obtain precertification.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

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Will you pay less if you use a <u>network provider</u> ?	Yes. See www.highmarkbcbsde.com or call 1-844-459-6452 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply	30% <u>coinsurance</u> <u>Deductible</u> does not apply	Coverage is limited by age, gender and risk parameters as identified in Highmark Delaware's Preventive Health Guidelines. Refer to www.highmarkbcbsde.com or call 1-800-633-2563 for specific information. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.

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Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com or call 1-800-939-2142	Generic drugs	\$8 <u>copay</u> /prescription for 30-day supply (retail or mail order); \$16 <u>copay</u> /prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in- <u>network</u> allowable amount minus applicable <u>copay</u>	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 <u>copay</u> 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. Qualified members ages 40 - 75 receive generic low to moderate dose statins at no cost. No charge for diabetic supplies purchased through the prescription plan. One copay applies for multiple diabetic medications filled at a 90-day participating retail pharmacy or Express Scripts Pharmacy, if purchased at the same time.
	Preferred brand drugs	\$28 <u>copay</u> /prescription for 30-day supply (retail or mail order); \$56 <u>copay</u> /prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in- <u>network</u> allowable amount minus applicable <u>copay</u>	
	Non-preferred brand drugs	\$50 <u>copay</u> /prescription for 30-day supply (retail or mail order); \$100 <u>copay</u> /prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in- <u>network</u> allowable amount minus applicable <u>copay</u>	
	<u>Specialty drugs</u>	<u>Copay</u> based on whether drug is generic, preferred, or non-preferred	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required for certain outpatient surgical procedures. If you don't get <u>preauthorization</u> , benefits will be denied.

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		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required for certain outpatient surgical procedures. If you don't get <u>preauthorization</u> , benefits will be denied.
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Care must be rendered within 48 hours of onset of symptoms.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$25 <u>copay</u> /visit <u>Deductible</u> does not apply	\$25 <u>copay</u> /visit <u>Deductible</u> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	Physician/surgeon fee	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in this SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 240 visits per <u>plan</u> year. <u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.

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		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
other special health needs	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Maximum number of Physical, Occupational and Speech Therapies is based on medical necessity.
	<u>Habilitation services</u>	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 120 days of care. Benefits renew after 180 days without care. <u>Preauthorization</u> is required. If you don't get <u>preauthorization</u> , benefits will be denied.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Coverage for hearing aids are limited to one hearing aid per ear every 3 years for children less than 24 years of age.
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 365 days of care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of these expenses.
	Children's glasses	Not covered	Not covered	You must pay 100% of these expenses.
	Children's dental check-up	No charge under Delta Dental or Dominion Dental	20% <u>coinsurance</u> under Delta Dental; not covered under Dominion Dental	Delta Dental: \$1,500 maximum per person per <u>plan</u> year; Dominion Dental: no maximum.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture Cosmetic surgery Glasses 	<ul style="list-style-type: none"> <u>Habilitation services</u> Long-term care (non-hospice) Routine eye care (Adult) 	<ul style="list-style-type: none"> Routine foot care (unless medically necessary) Weight loss programs

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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric surgery
- Chiropractic care (30 visits per [plan](#) year)
- Dental care (removal of bony impacted teeth; limited accidental injuries)
- Hearing aids (one hearing aid, per ear, every 3 years up to age 24)
- Infertility treatment (lifetime maximum: \$10,000 medical and \$15,000 prescription drug)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (non-hospice; inpatient care in acute hospital setting)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. You can also contact the [plan](#) at 1-844-459-6452. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Highmark Blue Cross Blue Shield Delaware at 1-844-459-6452 or 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.

Does this Coverage Provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Arabic (العربية): 1-800-489-8933 اتصل برقم

Chinese (繁體中文): 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-489-8933。

French (Français): Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-489-8933.

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French Creole (Kreyòl Ayisyen): Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-489-8933.

German (Deutsch): Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 1-800-489-8933.

Italian (Italiano): In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-489-8933.

Japanese (日本語): 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-489-8933 まで、お電話にてご連絡ください。

Korean (한국어): 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-489-8933 번으로 전화해 주십시오.

Persian-Farsi (فارسی): اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. 1-800-489-8933 تماس بگیرید

Polish (Polski): Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-489-8933.

Portuguese (Português): Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-489-8933.

Russian (Русский): Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-489-8933.

Spanish (Español): Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-489-8933.

Tagalog (Tagalog): Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-489-8933.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible :	\$500
■ Specialist coinsurance :	10%
■ Hospital (facility) coinsurance :	10%
■ Obstetric care coinsurance :	10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$30
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,790

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible :	\$500
■ Specialist coinsurance :	10%
■ Hospital (facility) coinsurance :	10%
■ Diagnostic test (blood work) coinsurance :	10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$600
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,360

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible :	\$500
■ Specialist coinsurance :	10%
■ Hospital (facility) coinsurance :	10%
■ Diagnostic test (x-ray) coinsurance :	10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$600