



Plan Year Deductibles¹

Individual \$2,000
 Family \$6,000
 Plan Year Coinsurance Limit : Individual/Family \$3,000/\$4,000

Preventive Medical Services

In Network Benefits

- | | |
|---------------------------------------|-----------------|
| • Periodic Physical Exams | Covered at 100% |
| • Routine Annual GYN Exam | Covered at 100% |
| • Routine Mammogram | Covered at 100% |
| • Routine Sigmoidoscopy & Colonoscopy | Covered at 100% |
| • Routine Pap Smear | Covered at 100% |
| • Routine Well-Child Care | Covered at 100% |
| • Immunizations | Covered at 100% |
| • Routine Vision Exams | Covered at 100% |
| • Routine Hearing Exams | Covered at 100% |
| • Prostate Screening Antigen Test | Covered at 100% |
| • Lead Poisoning Screening Test | Covered at 100% |

Treatment of Illness or Injury

In Network Benefits

- | | |
|---|---|
| • Primary Doctor's Office Visits for Diagnosis & Treatment | \$20 copay per visit |
| • Specialist/Referral Care | \$45 copay per visit ¹ |
| • Laboratory Services <ul style="list-style-type: none"> o Non-hospital based o Hospital based | \$10 copay per visit
Covered at 80% ¹ |
| • Imaging & Machine Testing Services <ul style="list-style-type: none"> o Non-hospital based o Hospital based | \$20 copay per visit
Covered at 80% ¹ |
| • Outpatient High Tech Radiology Non-Hospital and Hospital Based
(i.e. MRI, MRA, CT, CTA, PET scan) | Covered at 80% ¹ |
| • Chiropractic (up to 30 visits per Plan year) | \$45 copay per visit ¹ |
| • Physical & Occupational Therapy (30 visits combined per Plan year) | \$45 copay per visit ¹ |
| • Speech Therapy (30 visits per Plan Year) | \$45 copay per visit ¹ |
| • Radiation Therapy and Chemotherapy | \$45 copay per visit ¹ |
| • Inpatient Hospital <ul style="list-style-type: none"> o Semiprivate Room (including intensive care, if medically necessary) o Physician's & Surgeon's Services o Other Medical Professional Services | Covered at 80% ¹
Covered at 80% ¹
Covered at 80% ¹ |
| • Maternity (hospital, birthing center and pre-natal and post-natal care) | Not covered |
| • Outpatient Surgical Facility <ul style="list-style-type: none"> o Outpatient Ambulatory o Outpatient Hospital | Covered at 80% ¹
Covered at 80% ¹ |

Emergency Services

In Network Benefits

• Emergency Room	\$150 Copay ¹
• Urgent Care Centers / Medical Aid Units	\$45 Copay ¹
• Ambulance	Covered at 80% ¹

Other Services

In Network Benefits

• Inpatient Private Duty Nursing (up to 240 hours per 12 month period)	Covered at 80% ¹
• Prosthetic Devices and Durable Medical Equipment (DME)	Covered at 80% ¹
• Skilled Nursing Facility (up to 120 visits per confinement)	Covered at 80% ¹
• Home Health Care (up to 100 visits per Plan Year)	Covered at 80% ¹
• Alcohol and Substance Abuse Treatment ²	Covered same as medical
• Serious Mental Health Care ²	Covered same as medical
• Other Mental Health Care	
o Inpatient and Partial Hospitalization (up to 31 inpatient days or 62 partial hospitalization days per Plan Year. Two partial hospitalization days reduce inpatient days by one day. One inpatient day reduces partial hospitalization days by two days.	Covered at 80% ¹
o Outpatient (up to 20 visits per Plan Year)	\$45 Copay per visit ¹

Prescription Drugs

- Your prescription drug benefits have a contract year deductible that is separate from the health care plan deductible. Copayments you pay for prescription drugs are not applied to the drug deductible. Prescription drug co pays and coinsurance are not applied to the health care plan deductible or coinsurance expense limit.

Contract Year Deductible: \$1,000 per person.

Generic drugs are not subject to the deductible

Per Prescription or Refill: UP TO A 90-DAY SUPPLY

- Generic \$15 Copay 34-DAY SUPPLY; \$30 copay 35-90 DAY SUPPLY
- Preferred Brand covered 75% after deductible
- Non-Preferred Brand covered 50% after deductible

If an individual chooses a Preferred or Non-Preferred Brand drug when a Generic drug is available, he or she will have to pay the difference between the charge for the Preferred or Non-Preferred Brand drug and the Generic drug, plus the copay for the Generic Drug

1 Benefits are subject to a Plan Year deductible.

2 Delaware law defines serious mental illness as nine diagnostic classes. Benefits for serious mental illness and substance abuse treatment are covered at the same levels as other medical care.

If individual coverage is elected, the individual deductible will apply. Benefits are then covered at the indicated percentage for each service until the coinsurance totals the individual coinsurance limit. Benefits will then be paid at 100% of the allowable charge for the individual for the remainder of the Plan Year.

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. Benefits are then covered at the indicated percentage for each service until the coinsurance totals the family coinsurance limit. Benefits will then be paid at 100% of the allowable charge for all family members for the remainder of the Plan Year

Note: Applicable copays still apply after coinsurance expense limit has been reached. Blue Individual plans do not cover maternity services or bariatric surgery.

The plan includes preferred coverage for organ transplants performed at Blue Distinction Centers for Transplants (BDCT). For transplants performed at participating but non-BDCT facilities, charges are covered at a reduced benefit level. Transplants performed at non-participating facilities are not covered.

There are no Out-of-Network benefits. EPO members can access In-Network PPO providers anywhere in the Nation. If you are enrolling in the EPO Plan, you can take advantage of additional resources. The Blue Cross and Blue Shield Association's web site, bluecares.com, provides online access to the most current listing of providers, whether you need covered medical care close to home, across the country or around the world. On the bluecares.com home page, EPO enrollees should click on BlueCard® Doctor and Hospital Finder, provide the information requested, and choose the PPO Network option. Once you submit your information, you'll instantly receive an online list of network providers in the zip code requested—as well as driving directions to their offices or facilities. If you prefer personal help by phone, you can find network providers by calling a BlueCard customer service representative at 800.810.BLUE (2583).

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Plan Year Deductibles¹

Individual \$6,000
 Family \$18,000
 Plan Year Coinsurance Limit : Individual/Family \$4,000/\$2,000

Preventive Medical Services

In Network Benefits

• Periodic Physical Exams	Covered at 100%
• Routine Annual GYN Exam	Covered at 100%
• Routine Mammogram	Covered at 100%
• Routine Sigmoidoscopy & Colonoscopy	Covered at 100%
• Routine Pap Smear	Covered at 100%
• Routine Well-Child Care	Covered at 100%
• Immunizations	Covered at 100%
• Routine Vision Exams	Covered at 100%
• Routine Hearing Exams	Covered at 100%
• Prostate Screening Antigen Test	Covered at 100%
• Lead Poisoning Screening Test	Covered at 100%

Treatment of Illness or Injury

In Network Benefits

• Primary Doctor's Office Visits for Diagnosis & Treatment	\$20 copay per visit
• Specialist/Referral Care	\$45 copay per visit ¹
• Laboratory Services <ul style="list-style-type: none"> o Non-hospital based o Hospital based 	\$10 copay per visit Covered at 80% ¹
• Imaging & Machine Testing Services <ul style="list-style-type: none"> o Non-hospital based o Hospital based 	\$20 copay per visit Covered at 80% ¹
• Outpatient High Tech Radiology Non-Hospital and Hospital Based (i.e. MRI, MRA, CT, CTA, PET scan)	Covered at 80% ¹
• Chiropractic (up to 30 visits per Plan year)	\$45 copay per visit ¹
• Physical & Occupational Therapy (30 visits combined per Plan year)	\$45 copay per visit ¹
• Speech Therapy (30 visits per Plan Year)	\$45 copay per visit ¹
• Radiation Therapy and Chemotherapy	\$45 copay per visit ¹
• Inpatient Hospital <ul style="list-style-type: none"> o Semiprivate Room (including intensive care, if medically necessary) o Physician's & Surgeon's Services o Other Medical Professional Services 	Covered at 80% ¹ Covered at 80% ¹ Covered at 80% ¹
• Maternity (hospital, birthing center and pre-natal and post-natal care)	Not covered
• Outpatient Surgical Facility <ul style="list-style-type: none"> o Outpatient Ambulatory o Outpatient Hospital 	Covered at 80% ¹ Covered at 80% ¹

Emergency Services

In Network Benefits

• Emergency Room	\$150 Copay ¹
• Urgent Care Centers / Medical Aid Units	\$45 Copay ¹
• Ambulance	Covered at 80% ¹

Other Services

In Network Benefits

• Inpatient Private Duty Nursing (up to 240 hours per 12 month period)	Covered at 80% ¹
• Prosthetic Devices and Durable Medical Equipment (DME)	Covered at 80% ¹
• Skilled Nursing Facility (up to 120 visits per confinement)	Covered at 80% ¹
• Home Health Care (up to 100 visits per Plan Year)	Covered at 80% ¹
• Alcohol and Substance Abuse Treatment ²	Covered same as medical
• Serious Mental Health Care ²	Covered same as medical
• Other Mental Health Care	
o Inpatient and Partial Hospitalization (up to 31 inpatient days or 62 partial hospitalization days per Plan Year. Two partial hospitalization days reduce inpatient days by one day. One inpatient day reduces partial hospitalization days by two days.	Covered at 80% ¹
o Outpatient (up to 20 visits per Plan Year)	\$45 Copay per visit ¹

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Plan Year Deductibles¹

Individual \$1,500
 Family \$3,000
 Plan Year Coinsurance Limit : Individual/Family \$4,450/\$8,900

Preventive Medical Services

In Network Benefits

• Periodic Physical Exams	Covered at 100%
• Routine Annual GYN Exam	Covered at 100%
• Routine Mammogram	Covered at 100%
• Routine Sigmoidoscopy & Colonoscopy	Covered at 100%
• Routine Pap Smear	Covered at 100%
• Routine Well-Child Care	Covered at 100%
• Immunizations	Covered at 100%
• Routine Vision Exams	Covered at 100%
• Routine Hearing Exams	Covered at 100%
• Prostate Screening Antigen Test	Covered at 100%
• Lead Poisoning Screening Test	Covered at 100%

Treatment of Illness or Injury

In Network Benefits

• Primary Doctor's Office Visits for Diagnosis & Treatment	Covered at 100% ¹
• Specialist/Referral Care	Covered at 100% ¹
• Laboratory Services <ul style="list-style-type: none"> o Non-hospital based o Hospital based 	Covered at 100% ¹ Covered at 80% ¹
• Imaging & Machine Testing Services <ul style="list-style-type: none"> o Non-hospital based o Hospital based 	Covered at 100% ¹ Covered at 80% ¹
• Outpatient High Tech Radiology Non-Hospital and Hospital Based (i.e. MRI, MRA, CT, CTA, PET scan)	Covered at 80% ¹
• Chiropractic (up to 30 visits per Plan year)	Covered at 100% ¹
• Physical & Occupational Therapy (30 visits combined per Plan year)	Covered at 100% ¹
• Speech Therapy (30 visits per Plan Year)	Covered at 100% ¹
• Radiation Therapy and Chemotherapy	Covered at 100% ¹
• Inpatient Hospital <ul style="list-style-type: none"> o Semiprivate Room (including intensive care, if medically necessary) o Physician's & Surgeon's Services o Other Medical Professional Services 	Covered at 80% ¹ Covered at 80% ¹ Covered at 80% ¹
• Maternity (hospital, birthing center and pre-natal and post-natal care)	Not covered
• Outpatient Surgical Facility <ul style="list-style-type: none"> o Outpatient Ambulatory o Outpatient Hospital 	Covered at 80% ¹ Covered at 80% ¹

Emergency Services

In Network Benefits

• Emergency Room	Covered at 80% ¹
• Urgent Care Centers / Medical Aid Units	Covered at 100% ¹
• Ambulance	Covered at 80% ¹

Other Services

In Network Benefits

• Inpatient Private Duty Nursing (up to 240 hours per 12 month period)	Covered at 80% ¹
• Prosthetic Devices and Durable Medical Equipment (DME)	Covered at 80% ¹
• Skilled Nursing Facility (up to 120 visits per confinement)	Covered at 80% ¹
• Home Health Care (up to 100 visits per Plan Year)	Covered at 80% ¹
• Alcohol and Substance Abuse Treatment ²	Covered same as medical
• Serious Mental Health Care ²	Covered same as medical
• Other Mental Health Care	
o Inpatient and Partial Hospitalization (up to 31 inpatient days or 62 partial hospitalization days per Plan Year. Two partial hospitalization days reduce inpatient days by one day. One inpatient day reduces partial hospitalization days by two days.	Covered at 80% ¹
o Outpatient (up to 20 visits per Plan Year)	Covered at 100% ¹

Prescription Drugs

Per Prescription or Refill: UP TO A 90-DAY SUPPLY

• Generic	Covered at 100% ¹
• Preferred Brand	Covered at 75% ¹
• Non-Preferred Brand	Covered at 50% ¹

See Note below. You should obtain professional legal or tax advice concerning allowable HSA contribution amounts for these options.

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- 2 Delaware law defines serious mental illness as nine diagnostic classes. Benefits for serious mental illness and substance abuse treatment are covered at the same levels as other medical care.

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The plan includes preferred coverage for organ transplants performed at Blue Distinction Centers for Transplants (BDCT). For transplants performed at participating, but non-BDCT facilities, charges are covered at a reduced benefit level. Transplants performed at non-participating facilities are not covered.

When calculating deductible or coinsurance expenses, only the allowable charges are considered. All percentages listed above apply to Blue Cross Blue Shield of Delaware's allowable charge.

There are no out-of-network benefits. EPO members can access in-network providers in the national BlueCard® Network across the country. You can access the network by searching online at bluecares.com or by calling a BlueCard customer service representative at 800.810.BLUE.

Note: To establish and contribute to a Health Savings Account (HSA) you must be covered under a qualifying high deductible health plan (HDHP) and meet other eligibility requirements. These HDHPs are intended to be HSA-qualifying HDHPs. One of the other eligibility requirements is that you may not also be covered under another health plan that coordinates benefits with your HDHP, even if the other health plan also meets the requirements for an HDHP. You should obtain professional legal or tax advice before you establish or contribute to an HSA.

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Plan Year Deductibles¹

Individual \$2,000
 Family \$6,000
 Plan Year Coinsurance Limit : Individual/Family \$3,950/\$5,900

Preventive Medical Services

In Network Benefits

• Periodic Physical Exams	Covered at 100%
• Routine Annual GYN Exam	Covered at 100%
• Routine Mammogram	Covered at 100%
• Routine Sigmoidoscopy & Colonoscopy	Covered at 100%
• Routine Pap Smear	Covered at 100%
• Routine Well-Child Care	Covered at 100%
• Immunizations	Covered at 100%
• Routine Vision Exams	Covered at 100%
• Routine Hearing Exams	Covered at 100%
• Prostate Screening Antigen Test	Covered at 100%
• Lead Poisoning Screening Test	Covered at 100%

Treatment of Illness or Injury

In Network Benefits

• Primary Doctor's Office Visits for Diagnosis & Treatment	Covered at 100% ¹
• Specialist/Referral Care	Covered at 100% ¹
• Laboratory Services <ul style="list-style-type: none"> o Non-hospital based o Hospital based 	Covered at 100% ¹ Covered at 80% ¹
• Imaging & Machine Testing Services <ul style="list-style-type: none"> o Non-hospital based o Hospital based 	Covered at 100% ¹ Covered at 80% ¹
• Outpatient High Tech Radiology Non-Hospital and Hospital Based (i.e. MRI, MRA, CT, CTA, PET scan)	Covered at 80% ¹
• Chiropractic (up to 30 visits per Plan year)	Covered at 100% ¹
• Physical & Occupational Therapy (30 visits combined per Plan year)	Covered at 100% ¹
• Speech Therapy (30 visits per Plan Year)	Covered at 100% ¹
• Radiation Therapy and Chemotherapy	Covered at 100% ¹
• Inpatient Hospital <ul style="list-style-type: none"> o Semiprivate Room (including intensive care, if medically necessary) o Physician's & Surgeon's Services o Other Medical Professional Services 	Covered at 80% ¹ Covered at 80% ¹ Covered at 80% ¹
• Maternity (hospital, birthing center and pre-natal and post-natal care)	Not covered
• Outpatient Surgical Facility <ul style="list-style-type: none"> o Outpatient Ambulatory o Outpatient Hospital 	Covered at 80% ¹ Covered at 80% ¹

Emergency Services

In Network Benefits

• Emergency Room	Covered at 80% ¹
• Urgent Care Centers / Medical Aid Units	Covered at 100% ¹
• Ambulance	Covered at 80% ¹

Other Services

In Network Benefits

• Inpatient Private Duty Nursing (up to 240 hours per 12 month period)	Covered at 80% ¹
• Prosthetic Devices and Durable Medical Equipment (DME)	Covered at 80% ¹
• Skilled Nursing Facility (up to 120 visits per confinement)	Covered at 80% ¹
• Home Health Care (up to 100 visits per Plan Year)	Covered at 80% ¹
• Alcohol and Substance Abuse Treatment ²	Covered same as medical
• Serious Mental Health Care ²	Covered same as medical
• Other Mental Health Care	
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o Outpatient (up to 20 visits per Plan Year)	Covered at 100% ¹

Prescription Drugs

Per Prescription or Refill: UP TO A 90-DAY SUPPLY

• Generic	Covered at 100% ¹
• Preferred Brand	Covered at 75% ¹
• Non-Preferred Brand	Covered at 50% ¹

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 Family \$9,000
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Preventive Medical Services

In Network Benefits

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• Routine Annual GYN Exam	Covered at 100%
• Routine Mammogram	Covered at 100%
• Routine Sigmoidoscopy & Colonoscopy	Covered at 100%
• Routine Pap Smear	Covered at 100%
• Routine Well-Child Care	Covered at 100%
• Immunizations	Covered at 100%
• Routine Vision Exams	Covered at 100%
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• Prostate Screening Antigen Test	Covered at 100%
• Lead Poisoning Screening Test	Covered at 100%

Treatment of Illness or Injury

In Network Benefits

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Plan Year Deductibles¹

Individual \$1,800
 Family \$3,600
 Out of Network Plan Year coinsurance limit: Individual/Family \$3,450/\$6,900

Preventive Medical Services	In Network Benefits	Out of Network Benefits
• Periodic Physical Exams	Covered at 100%	Not covered
• Routine Annual GYN Exam	Covered at 100%	Not covered
• Routine Mammogram	Covered at 100%	Covered at 80%
• Routine Sigmoidoscopy & Colonoscopy	Covered at 100%	Covered at 80%
• Routine Pap Smear	Covered at 100%	Covered at 80%
• Routine Well-Child Care	Covered at 100%	Not covered
• Immunizations	Covered at 100%	Covered at 80%
• Routine Vision Exams	Covered at 100%	Not covered
• Routine Hearing Exams	Covered at 100%	Not covered
• Prostate Screening Antigen Test	Covered at 100%	Covered at 80%
• Lead Poisoning Screening Test	Covered at 100%	Covered at 80%

Treatment of Illness or Injury	In Network Benefits	Out of Network Benefits
• Primary Doctor's Office Visits for Diagnosis & Treatment	Covered at 100% ¹	Covered at 80% ¹
• Specialist/Referral Care	Covered at 100% ¹	Covered at 80% ¹
• Laboratory Services <ul style="list-style-type: none"> o Non-hospital based o Hospital based 	Covered at 100% ¹ Covered at 100% ¹	Covered at 80% ¹ Covered at 80% ¹
• Imaging & Machine Testing Services <ul style="list-style-type: none"> o Non-hospital based o Hospital based 	Covered at 100% ¹ Covered at 100% ¹	Covered at 80% ¹ Covered at 80% ¹
• Outpatient High Tech Radiology Non-Hospital and Hospital Based (i.e. MRI, MRA, CT, CTA, PET scan)	Covered at 100% ¹	Covered at 80% ¹
• Chiropractic (up to 30 visits per Plan year)	Covered at 100% ¹	Covered at 80% ¹
• Physical & Occupational Therapy (30 visits combined per Plan year)	Covered at 100% ¹	Covered at 80% ¹
• Speech Therapy (30 visits per Plan Year)	Covered at 100% ¹	Covered at 80% ¹
• Radiation Therapy and Chemotherapy	Covered at 100% ¹	Covered at 80% ¹
• Inpatient Hospital <ul style="list-style-type: none"> o Semiprivate Room (including intensive care, if medically necessary) o Physician's & Surgeon's Services o Other Medical Professional Services 	Covered at 100% ¹ Covered at 100% ¹ Covered at 100% ¹	Covered at 80% ¹ Covered at 80% ¹ Covered at 80% ¹
• Maternity (hospital, birthing center, pre-natal and post-natal care)	Not covered	Not covered
• Outpatient Surgical Facility <ul style="list-style-type: none"> o Outpatient Ambulatory o Outpatient Hospital 	Covered at 100% ¹ Covered at 100% ¹	Covered at 80% ¹ Covered at 80% ¹

Emergency Services	In Network Benefits	Out of Network Benefits
• Emergency Room	Covered at 100% ¹	Covered at 100% ¹
• Urgent Care Centers / Medical Aid Units	Covered at 100% ¹	Covered at 80% ¹
• Ambulance	Covered at 100% ¹	Covered at 80% ¹

Other Services	In Network Benefits	Out of Network Benefits
• Inpatient Private Duty Nursing (up to 240 hours per 12 month period)	Covered at 100% ¹	Covered at 80% ¹
• Prosthetic Devices and Durable Medical Equipment (DME)	Covered at 100% ¹	Covered at 80% ¹
• Skilled Nursing Facility (up to 120 visits per confinement)	Covered at 100% ¹	Covered at 80% ¹
• Home Health Care (up to 100 visits per Plan Year)	Covered at 100% ¹	Covered at 80% ¹
• Alcohol and Substance Abuse Treatment ²	Covered same as medical	Covered Same as Medical
• Serious Mental Health Care ²	Covered same as medical	Covered Same as Medical
• Other Mental Health Care		
o Inpatient and Partial Hospitalization (up to 31 inpatient days or 62 partial hospitalization days per Plan Year. Two partial hospitalization days reduce inpatient days by one day. One inpatient day reduces partial hospitalization days by two days.	Covered at 100% ¹	Covered at 80% ¹
o Outpatient (up to 20 visits per Plan Year)	Covered at 100% ¹	Covered at 80% ¹

Prescription Drugs	
Per Prescription or Refill: UP TO A 90-DAY SUPPLY	
• Generic	Covered at 100% ¹
• Preferred Brand	Covered at 100% ¹
• Non-Preferred Brand	Covered at 100% ¹

See Note below. You should obtain professional legal or tax advice concerning allowable HSA contribution amounts for these options.

- 1 Benefits are subject to a Plan Year deductible.
- 2 Delaware law defines serious mental illness as nine diagnostic classes. Benefits for serious mental illness and substance abuse treatment are covered at the same levels as other medical care.

If individual coverage is elected, the individual deductible will apply. Benefits are then covered at the indicated percentage for each service until the coinsurance totals the individual coinsurance limit. Benefits will then be paid at 100% of the allowable charge for the individual for the remainder of the Plan Year.

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. Benefits are then covered at the indicated percentage for each service until the coinsurance totals the family coinsurance limit. Benefits will then be paid at 100% of the allowable charge for all family members for the remainder of the Plan Year.

Blue Individual plans do not cover maternity services or bariatric surgery.

The plan includes preferred coverage for organ transplants performed at the Blue Distinction Centers for Transplants (BDCT). For transplants performed at participating but non-BDCT facilities, charges are covered at a reduced benefit level. Transplants performed at non-participating facilities are not covered.

When calculating deductible or coinsurance expenses, only the allowable charges are considered. All percentages listed above apply to Blue Cross Blue Shield of Delaware's allowable charge.

Members can access in-network providers in the national BlueCard® Network across the country. You can access the network by searching online at bluecares.com or by calling a BlueCard customer service representative at 800.810.BLUE.

Note: To establish and contribute to a Health Savings Account (HSA) you must be covered under a qualifying high deductible health plan (HDHP) and meet other eligibility requirements. These HDHPs are intended to be HSA-qualifying HDHPs. One of the other eligibility requirements is that you may not also be covered under another health plan that coordinates benefits with your HDHP, even if the other health plan also meets the requirements for an HDHP. You should obtain professional legal or tax advice before you establish or contribute to an HSA.

This Benefits Summary presents plan highlights only. It is not a contract. Please refer to your benefits booklet (or contact your marketing representative to request a copy) for complete information. All percentages are based on BCBS's allowable charge.

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BlueIndividual:

Important Limitations, Disclosures and Enrollment Information



BlueCross BlueShield
of Delaware

Eligibility

To be eligible to enroll in a Blue Cross Blue Shield of Delaware (BCBSD) **BlueIndividual** plan, you must be a Delaware resident between the ages of 18 and 64. You must be neither enrolled in, nor eligible for, Medicare and neither enrolled in, nor eligible for, BCBSD group coverage. Since these are medically underwritten plans, medical information for all individuals to be covered by the contract must be provided to BCBSD.

Additional eligibility requirements apply for establishing and contributing to a health savings account (HSA). Please see the Important Notes for Health Savings Accounts insert for more details.

Rating

Each subscriber's rate will be based on his or her age at the time of enrollment. Rates will be based on the age of the oldest covered adult applying. If you have more than one child, each additional child can be added to Individual and Child(ren) or Family coverage at no extra cost, subject to contract terms. A "child" must be under age 26.

Medical Underwriting

BCBSD **BlueIndividual** plans require medical underwriting and approval is not guaranteed. Medical underwriting is a systematic process that insurers use to evaluate information about a health insurance applicant. Based on medical underwriting reviews, you may be:

- ◆ Enrolled in your selected plan at the standard rate charge
- ◆ Enrolled in your selected plan at a higher rate
- ◆ Offered a different plan
- ◆ Declined coverage

Note: Individuals under age 19 cannot be refused coverage based on health status.

Other plans may be available to you without medical underwriting or preexisting condition waiting periods if you meet the criteria specified by HIPAA (Health Insurance Portability and Accountability Act). To find out more, please contact your broker or call BCBSD at **800.633.2563**.

Preexisting Conditions

A preexisting condition is any physical or mental condition of a covered person (a) for which medical advice, diagnosis, care or treatment was received within the 12 months prior to this contract being effective, or (b) that manifested symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis or treatment within the 12 months prior to this contract being effective. You may receive credit toward, or waiver of, the preexisting condition period if you enroll with us directly following termination (with no lapse) of other Blue Cross and Blue Shield coverage. We do not credit coverage from other carriers.

Note: Individuals under age 19 are not subject to a preexisting condition waiting period.

Individual Coverage

Coverage selected for one person is Individual coverage.

Family Coverage

Coverage selected for more than one person is Family coverage. There are three rates depending on the number of persons covered. They are:

- ◆ Individual & Child(ren): Coverage is for one adult and one or more children.
- ◆ Individual & Spouse: Coverage is for two adults who are married.
- ◆ Family: Coverage is for two adults who are married and one or more children.

Out-of-Pocket Expenses for Family Coverage

Please remember that when you select coverage for more than one person, the deductible and coinsurance are higher than the individual amount. The deductible and coinsurance amounts combine to equal the out-of-pocket expense. Any copays are excluded from the out-of-pocket maximum.

Deductibles

With both basic and HSA-compatible plans, there are no embedded deductibles. **One or more family members must satisfy the entire family deductible in any combination before benefits will be paid for any family member.**

(over)

(continued from front)

Medical Limitations and Exclusions

BlueIndividual plans do not cover all health care expenses and have exclusions and limitations.

BlueIndividual policies do not cover maternity services or bariatric surgery. Your **BlueIndividual** contract (mailed at time of enrollment) determines which health care services are covered and to what extent. All payments to providers are based on BCBSD's allowable charge. Please note, all of these medical plans have certain managed care requirements, such as our program for mental health and substance abuse care, and authorization for elective hospital admissions. Other requirements, as described in your contract, vary based on the benefits plan design.

You may request a copy of the exclusions before enrolling by calling us at **888.692.5830**. The following is a partial list of services and supplies that are generally not covered. Services generally not covered:

- ◆ Non-medically necessary services or supplies
- ◆ Medical expenses for a preexisting condition are generally not covered for the first 12 months
- ◆ Care BCBSD considers to be experimental or investigational
- ◆ Care for cosmetic reasons
- ◆ Any and all consequences or complications from, or related to, uncovered procedures, therapies or treatments
- ◆ Immunizations or inoculations for travel
- ◆ Infertility services, including artificial insemination or advanced reproductive technologies such as IVE, GIFT and ZIFT
- ◆ Speech, occupational or physical therapy for developmental delay

- ◆ Orthotic equipment or devices for feet
- ◆ Over-the-counter medications or supplies
- ◆ Physical exams for: potential employers, insurers, schools, camps, marriage or any other third party
- ◆ Pregnancy
- ◆ Care normally covered under Workers' Compensation
- ◆ Dental care
- ◆ Eyeglasses and all procedures for refractive correction
- ◆ Bariatric surgery

How to Receive In-Network Benefits — EPO/PPO Plans

To receive in-network benefits, see a preferred provider when you need care. The preferred providers are listed in the Provider Network Directory online at **bcbsd.com**.

Please note that some preferred providers are not approved by BCBSD to perform all health services at the in-network level. For example, a preferred hospital may not be approved as a preferred provider for outpatient lab tests.

You should always check the Provider Network Directory before you receive care.

There are no out-of-network benefits with an EPO plan. EPO/PPO members can access in-network providers in the national BlueCard® Network across the country. You can access the network by visiting **bluecares.com** and clicking Find a Doctor or Hospital, or by calling a BlueCard customer service representative at **800.810.BLUE (2583)**.

BlueIndividual plans require medical underwriting and are not guaranteed issue plans.



**BlueCross BlueShield
of Delaware**

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Blue Individual Product Rates*

Please note, if you or a family member uses a tobacco product, the policy will be subject to a 25% surcharge.

EPO \$20 \$2,000/\$6,000*				
Individual Deductible: \$2,000		Family Deductible: \$6,000		
Individual Coinsurance Max: \$3,000		Family Coinsurance Max: \$4,000		
Out-of-Pocket Max (In-network, excluding copays): \$5,000/\$10,000				
	Individual	Individual & Child(ren)	Individual & Spouse	Family
Adult <20	\$125	\$281	\$248	\$406
20-24	\$133	\$291	\$265	\$424
25-29	\$145	\$335	\$291	\$481
30-34	\$162	\$392	\$325	\$556
35-39	\$179	\$426	\$358	\$605
40-44	\$211	\$460	\$421	\$671
45-49	\$265	\$490	\$531	\$756
50-54	\$331	\$523	\$661	\$855
55-59	\$418	\$593	\$834	\$1,011
60-64	\$521	\$673	\$1,041	\$1,194

EPO \$20 \$6,000/\$18,000*				
Individual Deductible: \$6,000		Family Deductible: \$18,000		
Individual Coinsurance Max: \$4,000		Family Coinsurance Max: \$2,000		
Out-of-Pocket Max (In-network, excluding copays): \$10,000/\$20,000				
	Individual	Individual & Child(ren)	Individual & Spouse	Family
Adult <20	\$106	\$238	\$210	\$344
20-24	\$112	\$247	\$225	\$359
25-29	\$123	\$284	\$247	\$408
30-34	\$137	\$332	\$275	\$470
35-39	\$151	\$361	\$303	\$512
40-44	\$179	\$390	\$357	\$568
45-49	\$225	\$415	\$449	\$640
50-54	\$281	\$443	\$560	\$724
55-59	\$354	\$502	\$706	\$856
60-64	\$441	\$570	\$881	\$1,011

EPO HSA \$1,500/\$3,000*				
Individual Deductible: \$1,500		Family Deductible: \$3,000		
Individual Coinsurance Max: \$4,450		Family Coinsurance Max: \$8,900		
Out-of-Pocket Max: \$5,950/\$11,900				
	Individual	Individual & Child(ren)	Individual & Spouse	Family
Adult <20	\$109	\$247	\$218	\$356
20-24	\$116	\$255	\$233	\$372
25-29	\$128	\$294	\$255	\$422
30-34	\$142	\$345	\$285	\$487
35-39	\$157	\$374	\$314	\$531
40-44	\$185	\$404	\$370	\$588
45-49	\$233	\$430	\$466	\$663
50-54	\$290	\$459	\$580	\$749
55-59	\$366	\$521	\$732	\$887
60-64	\$456	\$590	\$913	\$1,047

EPO HSA \$2,000/\$6,000*				
Individual Deductible: \$2,000		Family Deductible: \$6,000		
Individual Coinsurance Max: \$3,950		Family Coinsurance Max: \$5,900		
Out-of-Pocket Max: \$5,950/\$11,900				
	Individual	Individual & Child(ren)	Individual & Spouse	Family
Adult <20	\$99	\$223	\$197	\$322
20-24	\$105	\$231	\$211	\$336
25-29	\$115	\$266	\$231	\$381
30-34	\$129	\$312	\$257	\$440
35-39	\$142	\$338	\$284	\$480
40-44	\$167	\$365	\$334	\$532
45-49	\$211	\$389	\$421	\$599
50-54	\$262	\$415	\$525	\$678
55-59	\$331	\$471	\$662	\$802
60-64	\$413	\$534	\$825	\$946

EPO HSA \$3,000/\$9,000*				
Individual Deductible: \$3,000		Family Deductible: \$9,000		
Individual Coinsurance Max: \$2,950		Family Coinsurance Max: \$2,900		
Out-of-Pocket Max: \$5,950/\$11,900				
	Individual	Individual & Child(ren)	Individual & Spouse	Family
Adult <20	\$92	\$209	\$185	\$301
20-24	\$99	\$216	\$197	\$315
25-29	\$108	\$249	\$216	\$357
30-34	\$121	\$292	\$241	\$413
35-39	\$133	\$317	\$266	\$450
40-44	\$157	\$342	\$313	\$499
45-49	\$197	\$364	\$395	\$562
50-54	\$246	\$389	\$492	\$635
55-59	\$310	\$441	\$620	\$751
60-64	\$387	\$500	\$774	\$887

PPO HSA \$1,800/\$3,600*				
Individual Deductible: \$1,800		Family Deductible: \$3,600		
Individual Coinsurance Max: N/A		Family Coinsurance Max: N/A		
Out-of-Pocket Max: \$1,800/\$3,600				
	Individual	Individual & Child(ren)	Individual & Spouse	Family
Adult <20	\$113	\$255	\$225	\$367
20-24	\$120	\$264	\$241	\$384
25-29	\$132	\$304	\$263	\$436
30-34	\$147	\$356	\$294	\$503
35-39	\$162	\$386	\$325	\$549
40-44	\$191	\$417	\$382	\$608
45-49	\$241	\$444	\$481	\$685
50-54	\$300	\$474	\$599	\$774
55-59	\$378	\$538	\$756	\$916
60-64	\$471	\$610	\$943	\$1,081

Monthly premium rates are effective for new customers enrolling between April 1, 2012 – June 30, 2012 and customers renewing April 1, 2012. Subject to review by the Delaware Department of Insurance. Rates are based on the age of the contract holder at the time of initial enrollment, and are adjusted at renewal when the contract holder ages into a new age band. Please note, plans require medical underwriting and are not guaranteed issue plans. * Coverage selected for more than one person is Family coverage. One or more family members must satisfy the entire family deductible in any combination before benefits will begin to be paid for any family members.