



BluePPO Individual

With a **PPO (Preferred Provider Organization) Plan** the choice is yours. You can save money by seeing an in-network provider. If you visit an out-of-network doctor or hospital, you are covered at the out-of-network level with higher out-of-pocket costs.

Benefits at a Glance

Please note: Deductible and out-of-pocket limits are shown for individual coverage. When you select coverage for more than one person, the amounts are double the individual amount.

In-Network Benefits

Deductible range: **\$1,500-\$5,000**
Benefit level: **80% covered**
Out-of-pocket maximum range
(excluding copays): **\$3,000-\$6,000**

Out-of-Network Benefits

Deductible range: **\$3,000-\$10,000**
Benefit level: **60% covered**
Out-of-pocket maximum range
(excluding copays): **\$6,000-\$12,000**

Lifetime limit (per individual): \$3,000,000

Benefit Examples	In-Network Coverage	Out-of-Network Coverage
Well-Child Care	\$10 copay	Not covered
Annual Physical Exams	\$10 copay	Not covered
Annual Gynecological Exams	\$10 copay	Not covered
Pap Smears and Prostate Screening Antigen Tests	100% covered	60% covered*
Periodic Routine Mammograms	100% covered	60% covered*
Doctor's Office Visits (PCP/Specialist)	\$10/\$20 copay	60% covered*
X-Rays	80% covered*	60% covered*
Labs	100% covered	60% covered*
Physical/Occupational Therapy	80% covered*	60% covered*
Emergency Room (Copay waived if admitted)	\$100 copay	\$100 copay
Ambulance	\$50 copay	\$50 copay
Inpatient/Outpatient Hospital & Associated Doctor Services	80% covered*	60% covered*

*Also subject to your benefit period deductible.

When calculating deductible or coinsurance expenses, only the allowable charge is considered. All benefits are subject to plan exclusions and limitations. Please see the *Limitations and Disclosures* insert for more information.

Prescription Drug Benefit

Until you satisfy your \$100 individual or \$200 family deductible:	After you satisfy your individual or family deductible:								
You will pay a discounted price for each prescription or refill.	<table> <tr> <td>When you select a drug in:</td> <td>Your copay will be:</td> </tr> <tr> <td>Tier 1: Generic equivalent</td> <td>\$0</td> </tr> <tr> <td>Tier 2: Preferred brand-name</td> <td>\$20</td> </tr> <tr> <td>Tier 3: Non-preferred brand-name</td> <td>\$45</td> </tr> </table>	When you select a drug in:	Your copay will be:	Tier 1: Generic equivalent	\$0	Tier 2: Preferred brand-name	\$20	Tier 3: Non-preferred brand-name	\$45
When you select a drug in:	Your copay will be:								
Tier 1: Generic equivalent	\$0								
Tier 2: Preferred brand-name	\$20								
Tier 3: Non-preferred brand-name	\$45								
<p>Mail order through Walgreens Mail Service: you pay two times the 34-day retail pharmacy copay (as indicated in the above chart) for up to a 90-day supply of medication.</p> <p>The plan pays up to a maximum of \$5,000 per individual, per benefit period, for prescription drugs.</p>									



BlueIPA Individual

An **IPA (Individual Practice Association) Plan**, similar to an HMO plan, keeps your out-of-pocket costs low, while covering most preventive care. Your primary care physician provides basic medical care — referring you to specialists and hospitals when needed. These plans have almost no coverage for out-of-network services.

Benefits at a Glance

Please note: Deductible and out-of-pocket limits are shown for individual coverage. When you select coverage for more than one person, the amounts are double the individual amount.

Deductible:	\$1,000
Benefit level:	100% covered
Out-of-pocket maximum:	N/A
Lifetime limit (per individual):	\$3,000,000

Benefit Examples	Coverage
Well-Child Care	\$20 copay
Annual Physical Exams	\$20 copay
Annual Gynecological Exams	\$20 copay
Pap Smears and Prostate Screening Antigen Tests	100% covered
Periodic Routine Mammograms	100% covered
Doctor's Office Visits (PCP/Specialist)	\$20/\$30 copay
X-Rays	100% covered*
Labs	100% covered*
Physical/Occupational Therapy	100% covered*
Emergency Room (Copay waived if admitted)	\$100 copay
Ambulance	\$50 copay
Inpatient/Outpatient Hospital & Associated Doctor Services	100% covered*

*Also subject to your benefit period deductible. When calculating deductible or coinsurance expenses, only the allowable charge is considered. All benefits are subject to plan exclusions and limitations. Please see the *Limitations and Disclosures* insert for more information.

Prescription Drug Benefit

Until you satisfy your \$100 individual or \$200 family deductible:	After you satisfy your individual or family deductible:								
You will pay a discounted price for each prescription or refill.	<table> <tr> <td>When you select a drug in:</td> <td>Your copay will be:</td> </tr> <tr> <td>Tier 1: Generic equivalent</td> <td>\$0</td> </tr> <tr> <td>Tier 2: Preferred brand-name</td> <td>\$20</td> </tr> <tr> <td>Tier 3: Non-preferred brand-name</td> <td>\$45</td> </tr> </table>	When you select a drug in:	Your copay will be:	Tier 1: Generic equivalent	\$0	Tier 2: Preferred brand-name	\$20	Tier 3: Non-preferred brand-name	\$45
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Tier 1: Generic equivalent	\$0								
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Mail order through Walgreens Mail Service: you pay two times the 34-day retail pharmacy copay (as indicated in the above chart) for up to a 90-day supply of medication. The plan pays up to a maximum of \$5,000 per individual, per benefit period, for prescription drugs.



BlueAdvantage Individual PPO

HSA Compatible Plan

A **high-deductible PPO (Preferred Provider Organization) Plan** works similarly to a basic PPO plan. You can save money by seeing an in-network provider. If you visit an out-of-network doctor or hospital, you are covered at the out-of-network level with higher out-of-pocket costs. With a high-deductible PPO plan, you may also contribute to a tax-favored Health Savings Account (HSA) and use those funds to pay for out-of-pocket medical costs. Consult a competent tax professional before you make any withdrawals from your HSA.

Benefits at a Glance

Please note: Deductible and out-of-pocket limits are shown for individual coverage. When you select coverage for more than one person, the amounts are double the individual amounts.

Deductible range (in-network):	\$1,800-\$2,700
Deductible range (out-of-network):	\$1,800-\$2,700
Benefit level (in-network):	100%
Benefit level (out-of-network):	80%
Out-of-pocket maximum range (in-network):	\$1,800-\$2,700
Lifetime limit (per individual):	\$3,000,000

Benefit Examples	In-Network Coverage	Out-of-Network Coverage
Well-Child Care	100% covered	Not covered
Annual Physical Exams	100% covered	Not covered
Annual Gynecological Exams	100% covered	Not covered
Pap Smears and Prostate Screening Antigen Tests	100% covered	80%*
Periodic Routine Mammograms	100% covered	80%*
Doctor's Office Visits (<i>PCP/Specialist</i>)	100%*	80%*
X-Rays	100%*	80%*
Labs	100%*	80%*
Physical/Occupational Therapy	100%*	80%*
Emergency Room	100%*	80%*
Ambulance	100%*	80%*
Inpatient/Outpatient Hospital & Associated Doctor Services	100%*	80%*
Prescription Drugs (<i>Discounted cost</i>)	100%*	Covered same as in-network

*Also subject to your benefit period deductible.

Note, your prescription drug benefit has a combined deductible with the medical plan. When calculating deductibles, coinsurance expenses or out-of-pocket maximums, only the allowable charge is considered. All benefits are subject to plan exclusions and limitations. Please see the *Limitations and Disclosures* insert for more information.



Limitations and Disclosures

Please see the Important Disclosures and Enrollment Information page of the brochure for more information.

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. Since these are medically underwritten plans, medical information for all individuals to be covered by the contract must be provided to BCBSD.

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 spouse 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" is your child under age 24.

Add Optional Maternity Benefit

With **BlueIndividual** plans, you have the option of adding maternity coverage to any of our plans for an additional \$227 per month. *Benefits for the maternity option are subject to:*

- ◆ A coverage waiting period of 12 months
- ◆ A \$4,000 maximum

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 double 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.

Basic Plans

Basic plans have an embedded deductible. The following example describes how an embedded deductible would work for a family coverage plan with a \$1,500 individual/\$3,000 family deductible and 80 percent coinsurance:

- 1) If claims for one person meet \$1,500, BCBSD will apply \$1,500 toward the family deductible (for this person). Future claims for that person will then be paid at 80 percent. Another family member will need to meet the \$1,500 individual deductible before the family deductible is satisfied.

- 2) If two family members each meet their \$1,500 individual deductible, the family deductible is satisfied. Future claims for the entire family will then be paid at 80 percent.
- 3) If no one meets the individual deductible, the family deductible *is not satisfied* even if the combination of all family claims equals \$3,000. Only when two individuals meet their individual deductibles will all family claims be paid at 80 percent.

HSA-Compatible Plans

Unlike the basic plans, with 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.

Medical Limitations and Exclusions

These medical plans do not cover all health care expenses. These plans also have various exclusions and limitations. Your **BlueIndividual** contract (mailed at time of enrollment) determines which health care services are covered and to what extent. You may request a copy of the exclusions before enrolling by calling us at **888.692.5830**. A partial list of services and supplies that are generally not covered is available on page six of the **BlueIndividual** brochure.

How to Receive In-Network Benefits — 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 or online at **bcbstd.com**. If you receive care using a preferred provider, your benefits are higher. This means, BCBSD's share of payment is greater.

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.

How to Receive Out-Of-Network Benefits — PPO Plans

With Out-of-Network benefits, you may see any provider you choose; however, your share of the payment is greater. *First*, there are higher deductibles and coinsurance. *Second*, if you see a *non-participating provider*, you will be responsible for any balance over BCBSD's allowable charge. This is because *non-participating providers* don't have contracts with BCBSD.

Third, when choosing a provider, there are ways to save money. Many doctors and other providers contract with BCBSD. These providers agree to accept BCBSD's allowable charge as full payment. They are called "participating providers." They cannot bill you more than our allowable charge, even if their normal charge is higher. And, these providers file claims with BCBSD for you. So, you don't need to complete claim forms.

Be sure to ask if your provider participates with BCBSD.

BlueIndividual Product Rates*

PPO \$1,500				
Deductible (In-network): \$1,500		Deductible (Out-of-network): \$3,000		
Benefit Level (In-network): 80%		Benefit Level (Out-of-network): 60%		
Coinsurance Max (In-network): \$1,500		Rx: \$0/20/45, \$100 Ded		
Out-of-Pocket Max (In-network, excluding copays): \$3,000				
	Individual	Individual & Child(ren)	Individual & Spouse	Family
Adult <20	\$157	\$356	\$315	\$513
20-24	\$168	\$368	\$336	\$537
25-29	\$184	\$425	\$368	\$610
30-34	\$205	\$498	\$411	\$703
35-39	\$227	\$540	\$454	\$767
40-44	\$267	\$583	\$534	\$850
45-49	\$336	\$621	\$673	\$957
50-54	\$419	\$663	\$838	\$1,082
55-59	\$528	\$752	\$1,057	\$1,280
60-64	\$659	\$853	\$1,318	\$1,512

PPO \$2,500				
Deductible (In-network): \$2,500		Deductible (Out-of-network): \$5,000		
Benefit Level (In-network): 80%		Benefit Level (Out-of-network): 60%		
Coinsurance Max (In-network): \$1,500		Rx: \$0/20/45, \$100 Ded		
Out-of-Pocket Max (In-network, excluding copays): \$4,000				
	Individual	Individual & Child(ren)	Individual & Spouse	Family
Adult <20	\$145	\$327	\$289	\$472
20-24	\$155	\$338	\$308	\$493
25-29	\$169	\$390	\$338	\$560
30-34	\$188	\$457	\$378	\$646
35-39	\$209	\$496	\$417	\$705
40-44	\$245	\$536	\$490	\$781
45-49	\$308	\$571	\$618	\$879
50-54	\$385	\$610	\$770	\$994
55-59	\$485	\$691	\$971	\$1,176
60-64	\$605	\$784	\$1,211	\$1,389

PPO \$5,000				
Deductible (In-network): \$5,000		Deductible (Out-of-network): \$10,000		
Benefit Level (In-network): 80%		Benefit Level (Out-of-network): 60%		
Coinsurance Max (In-network): \$1,000		Rx: \$0/20/45, \$100 Ded		
Out-of-Pocket Max (In-network, excluding copays): \$6,000				
	Individual	Individual & Child(ren)	Individual & Spouse	Family
Adult <20	\$125	\$283	\$250	\$407
20-24	\$134	\$292	\$266	\$426
25-29	\$146	\$337	\$292	\$484
30-34	\$163	\$395	\$327	\$558
35-39	\$180	\$428	\$360	\$609
40-44	\$212	\$463	\$424	\$675
45-49	\$266	\$493	\$534	\$760
50-54	\$332	\$527	\$665	\$859
55-59	\$419	\$597	\$839	\$1,016
60-64	\$523	\$677	\$1,046	\$1,200

IPA \$20/\$1,000				
PCP: \$20		Specialist: \$30		
Deductible: \$1,000		Rx: \$0/20/45, \$100 Ded		
Coinsurance Max: N/A		Out-of-Pocket Max: N/A		
	Individual	Individual & Child(ren)	Individual & Spouse	Family
Adult <20	\$156	\$354	\$313	\$510
20-24	\$167	\$366	\$334	\$533
25-29	\$183	\$422	\$366	\$606
30-34	\$204	\$495	\$409	\$698
35-39	\$226	\$536	\$451	\$762
40-44	\$265	\$579	\$530	\$845
45-49	\$334	\$618	\$668	\$951
50-54	\$416	\$659	\$833	\$1,075
55-59	\$525	\$748	\$1,051	\$1,272
60-64	\$655	\$848	\$1,310	\$1,502

PPO HSA \$1,800/\$3,600 / 100%/80% [†]				
Deductible (In-network): \$1,800		Deductible (Out-of-network): \$1,800		
Benefit Level (In-network): 100%		Benefit Level (Out-of-network): 80%		
Coinsurance Max (In-network): \$0		Rx: Integrated		
Out-of-Pocket Max (In-network): \$1,800				
	Individual	Individual & Child(ren)	Individual & Spouse	Family
Adult <20	\$107	\$243	\$215	\$351
20-24	\$115	\$252	\$229	\$366
25-29	\$126	\$290	\$251	\$416
30-34	\$140	\$340	\$280	\$480
35-39	\$155	\$369	\$310	\$523
40-44	\$182	\$398	\$364	\$580
45-49	\$229	\$424	\$459	\$653
50-54	\$286	\$453	\$572	\$739
55-59	\$361	\$513	\$721	\$874
60-64	\$450	\$582	\$900	\$1,032

PPO HSA \$2,700/\$5,400 / 100%/80% [†]				
Deductible (In-network): \$2,700		Deductible (Out-of-network): \$2,700		
Benefit Level (In-network): 100%		Benefit Level (Out-of-network): 80%		
Coinsurance Max (In-network): \$0		Rx: Integrated		
Out-of-Pocket Max (In-network): \$2,700				
	Individual	Individual & Child(ren)	Individual & Spouse	Family
Adult <20	\$91	\$207	\$183	\$298
20-24	\$97	\$214	\$195	\$311
25-29	\$107	\$246	\$214	\$353
30-34	\$119	\$288	\$238	\$408
35-39	\$132	\$313	\$263	\$445
40-44	\$155	\$338	\$309	\$493
45-49	\$195	\$360	\$390	\$555
50-54	\$243	\$385	\$486	\$627
55-59	\$306	\$436	\$613	\$742
60-64	\$382	\$494	\$764	\$877

[†]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 member. *Monthly premium rates are effective for new customers enrolling between April 1, 2010–June 30, 2010 and customers renewing April 1, 2010. 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.

Additional monthly rate for maternity benefit is \$227. Please note, these plans require medical underwriting and are not guaranteed issue plans.

Blue Cross Blue Shield of Delaware is an independent licensee of the Blue Cross and Blue Shield Association.