As required by the Patient Protection & Affordable Care Act, this coverage meets the minimum value standard and the cost of this coverage to the employee is intended to be affordable, based on the employee's wages.

Kent County Levy Court

Plan/Contract Year effective: July 1, 2014 - June 30, 2015

Summary of Benefits EPO 100 $5000/$10,000

Benefit	IN Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible Aggregate Individual Family Highmark pays the deductible & County reimburses Ins. Co	 $5,000 $10,000	 N/A N/A
Plan Pays – payment based on the plan allowance	100% after deductible	N/A
Coinsurance Maximum - (per benefit period) Individual Family	 N/A N/A	 N/A N/A
Total Maximum Out of Pocket (includes medical deductible, coinsurance, copays Network only). Once met, plan pays 100% of covered services for the rest of the benefit period. Individual Family County Does Not Pay Copays or Amounts Over Benefit Limit	 $6,350 $12,700	 N/A N/A
Office/Clinic/Urgent Care Visits		
Primary Care Provider Office Visits	$10 copay	Not Covered
Specialist Office Visits	$20 copay	Not Covered
Urgent Care Center Visits	$20 copay	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	100% (deductible does not apply) One routine eye exam every 24 months	Not Covered
Pediatric Vision: Routine Vision Exam	100% (deductible does not apply) One routine eye exam every 12 months Performed at time of physical by PCP	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 copay per visit (waived if admitted)	
Ambulance	100% after deductible	
Outpatient Therapy Rehabilitation Services		

Benefit	IN Network	Out-of-Network
Physical and Occupational Therapy	$20 copay	Not Covered
	Limit: 30 visits/benefit period combined PT and OT	
Cognitive Therapy	$20 copay	Not Covered
Speech Therapy	$20 copay	Not Covered
	Limit: 30 visits per therapy/benefit period	
Chiropractic	100% after deductible	Not Covered
	Limit: 30 visits/benefit period	
Cardiac Rehab	$20 copay	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	$10 copay per visit	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	
Hospice	100% after deductible	Not Covered
Private Duty Nursing	100% after deductible	Not Covered
	Limit: 240 hours/benefit period - Inpatient Only	
Skilled Nursing Facility Care	100% after deductible	Not Covered
	Limit: 120 days/benefit period	
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 34 day supply		
Prescription Drug Program *Your plan uses the Comprehensive Formulary* *90 day supply (2) copays*	Generic $10 copay Preferred Brand $25 copay Non-Preferred Brand $50 copay	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.

Note:

This plan includes reduced coverage for bariatric surgeries.

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 1.800.810.BLUE (2583).

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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This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.