

# CITY OF WILMINGTON – FY 24

## Actives

### Summary of EPO 100% \$500/\$1,500 Deductible Group 10162729

On the chart below, you'll see what your plan pays for specific services. *You are responsible for paying for non-emergency services received from an out-of-network provider.* You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

General Provisions	
<b>Benefit Period</b> <sup>(1)</sup>	Contract Year
<b>Deductible</b> (per benefit period)	
Individual	\$500
Family	\$1,500
<b>Plan Pays</b> – payment based on the plan allowance	100% after deductible
<b>Out-of-Pocket Limit</b> (Once met, plan pays 100% coinsurance for the rest of the benefit period)	
Individual	\$0
Family	\$0
<b>Total Maximum Out-of-Pocket</b> (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) <sup>(2)</sup> Once met, the plan pays 100% of covered services for the rest of the benefit period.	
Individual	\$3,300
Family	\$6,600
Office/Urgent Care Visits	
<b>Primary Care Provider Office Visits &amp; Virtual Visits</b>	100% after \$30 copayment
<b>Specialist Office &amp; Virtual Visits</b>	100% after \$30 copayment
Virtual Visit Originating Site Fee	100% after \$30 copayment
<b>Urgent Care Center Visits</b>	100% after \$30 copayment
Preventive Care <sup>(3)</sup>	
<b>Routine Adult</b>	
Physical exams	100% (deductible does not apply)
Adult immunizations	100% (deductible does not apply)
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)
Mammograms	
Annual Routine	100% (deductible does not apply)
Medically Necessary	100% after deductible
Diagnostic services and procedures	100% (deductible does not apply)
<b>Routine Pediatric</b>	
Physical exams	100% (deductible does not apply)
Pediatric immunizations	100% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)
Emergency Services	
<b>Emergency Room Services</b>	100% after \$150 copayment (copayment waived if admitted)
<b>Ambulance</b>	\$50 copayment per occurrence then 100%, no deductible
Hospital and Medical/Surgical Expenses (including Maternity)	
<b>Hospital Inpatient</b>	100% after deductible
<b>Hospital Outpatient</b>	100% after deductible
<b>Maternity</b> (non-preventive facility & professional services) including dependent daughter	100% after deductible
<b>Medical Care</b> (including inpatient visits and consultations)/ <b>Surgical Expenses</b>	100% after deductible
Therapy and Rehabilitation Services	
	100% after deductible
<b>Physical Therapy &amp; Occupational Therapy</b>	<b>Benefit Limit:</b> 60 visit limit per acute condition beginning the 1 <sup>st</sup> day of treatment; services related to the treatment of back pain are excluded from visit limits
<b>Respiratory Therapy</b>	100% after deductible
<b>Speech Therapy</b>	100% after deductible
	<b>Benefit Limit:</b> Limit: 60 visits per benefit period
<b>Spinal Manipulations/Chiropractic Care</b>	100% after deductible

	<b>Benefit Limit:</b> Limit: 30 visits per benefit period; services related to the treatment of back pain are excluded from visit limits
<b>Cardiac Rehabilitation Therapy</b>	100% after deductible
<b>Other Therapy Services</b> (Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible
<b>Mental Health/Substance Abuse</b>	
<b>Inpatient Mental Health Services</b>	100% after deductible
<b>Inpatient Detoxification/Rehabilitation</b>	100% after deductible
<b>Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits</b>	100% after \$30 copayment
<b>Outpatient Substance Abuse</b>	100% after \$30 copayment
<b>Other Services</b>	
<b>Allergy Extracts and Injections</b>	PCP or Specialist Office Visit copayment applies, then 100%
<b>Applied Behavior Analysis for Autism Spectrum Disorder</b> (5)	100% after deductible
<b>Assisted Fertilization Procedures</b>	100% after deductible
<b>Dental Services Related to Accidental Injury</b>	PCP or Specialist Office Visit copayment applies, then 100%
<b>Diagnostic Services</b>	
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible
Standard Imaging	100% after deductible
Diagnostic Medical	100% after deductible
Pathology/Laboratory	100% after deductible
Allergy Testing	\$30 copay, then 100% (not subject to deductible) One copay per day, per provider
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100% after deductible
<b>Home Health Care</b>	100% after deductible <b>Benefit Limit:</b> Limit: 100 visits per benefit period; aggregate with Visiting Nurse
<b>Hospice</b>	100% after deductible
<b>Infertility Counseling, Testing and Treatment</b> (4)	100% after deductible
<b>Private Duty Nursing</b>	100% after deductible <b>Benefit Limit:</b> Limited to Inpatient Only - Covered up to 240 hours per benefit period
<b>Skilled Nursing Facility Care</b>	100% after deductible <b>Benefit Limit:</b> Limit: 120 days per confinement; benefits renew after 180 days without care
<b>Transplant Services</b>	100% after deductible for services received at a BDTC (Blue Distinction Total Care) facility; benefit reduction of 20% for services received at other facilities
<b>Precertification Requirements</b> (5)	Yes
<b>Prescription Drugs</b>	
<b>Prescription Drugs</b>	Not Administered by Highmark

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy / plan documents, as limitations and exclusions apply. The policy / plan documents control in the event of a conflict with this benefit summary.

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. The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government, TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
3. Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
4. Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
5. Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.

**Discrimination is Against the Law**

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the claims administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

*Please note that your plan sponsor – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/program.*

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

Geb Acht: Wann du Deutsch schwetzsch, kannscht du en Dolmetscher griegie, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આપેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ប្រការចងចាំ ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមសួរសុំលេខទូរស័ព្ទដែលមាននៅលើខ្នង កាត់សម្គាល់របស់របស់លោកអ្នក ( TTY: 711 ) ។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود ( TTY: 711 ) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yánilti'go, language assistance services, éí t'áá níik'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitínígfí bine'déé' (TTY: 711) jį' hodíílnih.

ધ્યાન દે: યદાિઆપ હનિદી બોલતે હૈ, તો આપકે લરિ નિ:શિલુક ભાષા સહાયતા સેવા ઉપલબ્ધ હૈ। આપકે સદસ્ય પહચાન (ID) કાર્ડ કે પીછે દરિ ગર નંબર પર ફોન કરૈ। (TTY: 711).

توجه: فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడతే, లాగివేక అసనఁతినన సరవేసన, ఛారఁకీ లెకుండా, మీకు అందుబాటులే ఉననాయె. మీ మంబర డిఁటిఫికేషన్ కార్డు (పఁడి) వినక ఉనన నంబరుకు కాలఁ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้ถูก โดยไม่มีค่าใช้จ่าย โทรไปยัง หมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ધ્યાન દનિહોસ: યદતિપાઈ નેપાલી ભાષા બોલનુહુનુહુ બને, તપાઈકા લાગિભાષા સહાયતા સેવાહરુ નિ:શિલુક ઉપલબ્ધ હુનુહુનુ। તપાઈકો આઈડી કાર્ડકો પછાડાિ ભાગમા રહેકો નમ્બર (TTY: 711) મા ફોન ગરનુહોસ।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).