Delaware River & Bay Authority – Client # 134009
Group #'s 10008258, 10008260, 10006159

Summary of PPO 100 *Benefits – January 2025*

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Benefit	IN Network	Out-of-Network
General Provisions		
Benefit Period [1]	Contract Year	
Deductible (**Embedded**)– (per benefit period) [2] Individual Family	 None None	 $300 $900
Plan Pays – payment based on the plan allowance	100% unless otherwise indicated	80% after deductible
Coinsurance Maximum - (per benefit period) Individual Family	 None None	 $1,500 $4,500
Total Maximum Out of Pocket[3] **(Embedded)** (Medical In-Network deductible, coinsurance, and copays COMBINE with Pharmacy Copays). Once met, plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $9,200 $18,400	 N/A N/A
Office/Clinic/Urgent Care Visits		
Primary Care Provider Office Visits	$15 copay	80% after deductible
Specialist Office Visits	$20 copay	80% after deductible
Telemedicine	$15 copay	Not Covered
Urgent Care Center Visits	$20 copay	80% after deductible
Preventive Care [3]		
Routine Adult Physical exams	 100% no copay	 80% after deductible
Adult immunizations	100% no copay	80% after deductible
Colorectal cancer screening	100% no copay	80% after deductible
Routine gynecological exams, Pap Test	100% no copay	80% after deductible
Routine Mammogram	100% no copay	80% after deductible
Prostate Specific Antigen Test	100% no copay	80% after deductible
Routine Pediatric Physical exams	100% no copay 100% no copay	 80% after deductible
Pediatric immunizations	100% no copay	80% after deductible
Vision Adult: Routine Vision Exam Pediatric Vision: Routine Vision Exam	 $20 copay One routine eye exam every 24 months $20 copay One routine eye exam every 12 months	 Not Covered Not Covered
Hospital and Medical/Surgical Expenses (including Maternity)		
Hospital Inpatient	$75 copay per day for the first 4 days. Calendar Year maximum of $300 copay per Individual. Then covered at 100%	80% after deductible
Hospital Outpatient	Covered at 100%	80% after deductible
Maternity (non-preventive facility & professional services)	Covered at 100%	80% after deductible
Surgical Inpatient	Covered at 100%	80% after deductible
Surgical Outpatient (except office visits)	Covered at 100%	80% after deductible
Ambulatory Surgery	Covered at 100%	80% after deductible
Anesthesia	Covered at 100%	80% after deductible
Emergency Services		
Emergency Room Services	$150 copay per visit (waived if admitted)	

Benefit	IN Network	Out-of-Network
Ambulance	$25 copay per service	
Outpatient Therapy Rehabilitation Services		
Physical and Occupational Therapy	Covered at 80%	80% after deductible
	Limit: 60 visits/benefit period combined PT and OT - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Speech Therapy	Covered at 80%	80% after deductible
	Limit: 60 visits /benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	
Chiropractic	$20 copay per visit	80% after deductible
	Limit: 30 visits/benefit period	
Cardiac Therapy	Covered at 80%	80% after deductible
Chemotherapy and Radiation Therapy	Covered at 100%	80% after deductible
Mental Health/Substance Abuse		
Inpatient	$75 copay per day for the first 4 days. Calendar Year maximum of $300 copay per Individual. Then covered at 100%	80% after deductible
Inpatient Detoxification/Rehabilitation	$75 copay per day for the first 4 days. Calendar Year maximum of $300 copay per Individual. Then covered at 100%	80% after deductible
Outpatient	Covered at 100%	80% after deductible
Other Services		
Assisted Fertilization Procedures	$600 Maximum Benefit for Artificial Insemination	
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)		
Hospital Facility	$225 copay	80% after deductible
Non Hospital Facility	$75 copay	80% after deductible
Standard Imaging (including diagnostic mammograms)		
Hospital Facility	$80 copay	80% after deductible
Non Hospital Facility	$20 copay	80% after deductible
Laboratory		
Hospital Facility	$80 copay	80% after deductible
Non Hospital Facility	$20 copay	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	Covered at 80%	80% after deductible
Home Health Care	Covered at 100%	80% after deductible
	Limit: 100 visits/benefit period	
Hospice	Covered at 100%	80% after deductible
Private Duty Nursing	Covered at 100%	80% after deductible
	Limit: 240 hours/benefit period - Inpatient Only	
Skilled Nursing Facility Care	Covered at 100%	80% after deductible
	Limit: 120 days/benefit period	
Transplant Services	For organ transplants preformed at Blue Distinction Centers for Transplants (BDCT), charges are covered at 100%. For transplants performed at participating but non-BDCT facilities, charges are covered at a reduced benefit level of 80%.	Not Covered
Precertification Requirements (4)	Yes	
Prescription Drugs **Administered by ESI Direct not Highmark Delaware** **Information available at www.express-scripts.com**	Generic Drugs $10 copay Preferred Brand Drugs $20 copay Non-Preferred $35 copay Some drugs require prior authorization and/or have quantity limits. Covers up to a 30 day supply (retail) 31-90 day supply mail order	Not Covered

(1) Your group's benefit period is based on a Calendar Year. The Calendar Year is a consecutive 12-month period beginning on January 1st.
(2) When calculating deductible expenses, only the allowable charges are considered
(3) 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. If you are enrolled in a ''Family plan'', with your embedded deductible, only one eligible family member must satisfy his/her individual deductible before claims reimbursement begins. In addition, with your embedded out-of-pocket limit, once an individual family member's out-of-pocket limit is satisfied, additional claims reimbursement begins for that person. Finally, with your embedded TMOOP, once any eligible family member satisfies his/her individual TMOOP, claims will pay at 100% of the plan allowance for covered expenses, for the rest of the plan year.
(4) Services are limited to those listed on the Highmark Delaware Preventive Schedule.

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

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.