Delaware River & Bay Authority – Client # 134009
Group #'s 10121033, 10121034, 10162097, 10622489

HIGHMARK. Delaware

Summary of EPO $15/$35 100% *Benefits – January 2027*

Benefit	IN Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (Embedded) Individual Family	 $200 $400	 N/A N/A
Plan Pays – payment based on the plan allowance	100% unless otherwise indicated	N/A
Coinsurance Maximum - (per benefit period) Individual Family	 None None	 N/A N/A
Total Maximum Out of Pocket(2) **(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	 $12,000 $24,000	 N/A N/A
Office/Clinic/Urgent Care Visits		
Primary Care Provider Office Visits – includes virtual	$15 copay	Not Covered
Specialist Office Visits – includes virtual	$35 copay	Not Covered
Telemedicine	$15 copay	Not Covered
Urgent Care Center Visits	$35 copay	Not Covered
Preventive Care(3)		
Routine Adult(3) 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 100%; deductible does not apply	 Not Covered
Pediatric immunizations	100%; deductible does not apply	Not Covered
Vision Adult: Routine Vision Exam	 100% after $35 copayment; deductible does not apply One routine eye exam every 24 months	 Not Covered
Pediatric Vision: Routine Vision Exam	100% after $35 copayment; deductible does not apply One routine eye exam every 12 months	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 (must be performed by an in network facility & surgeon)	100% after Deductible	
Emergency Services		
Emergency Room Services	100% after $150 copayment per visit (waived if admitted); deductible does not apply	
Ambulance	100% after $25 copayment per occurrence; deductible does not apply	
Outpatient Therapy Rehabilitation Services		

Benefit	IN Network	Out-of-Network
Physical and Occupational Therapy	80% covered; deductible does not apply	Not Covered
	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	80% covered; deductible does not apply - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse	Not Covered
	Limit: 60 visits /benefit period	
Chiropractic	100% covered after $35 copayment; deductible does not apply	Not Covered
	Limit: 30 visits/benefit period	
Cardiac Rehab	80% covered; deductible does not apply	Not Covered
Chemotherapy and Radiation Therapy	100% covered; deductible does not apply	Not Covered
Mental Health/Substance Abuse		
Inpatient	100% after Deductible	Not Covered
Inpatient Detoxification/Rehabilitation	100% after Deductible	Not Covered
Outpatient	100% covered	Not Covered
Other Services		
Assisted Fertilization Procedures	$600 maximum benefit for Artificial Insemination/Intrauterine Insemination	Not Covered
Diagnostic Services **Advanced Imaging (MRI, CAT, PET scan, etc.)** **Hospital Facility** **Non Hospital Facility**	 100% covered after $225 copay; deductible does not apply 100% covered after $75 copay; deductible does not apply	 Not Covered Not Covered
Standard Imaging (including diagnostic mammograms) **Hospital Facility** **Non Hospital Facility**	 100% covered after $80 copay; deductible does not apply 100% covered after $20 copay; deductible does not apply	 Not Covered Not Covered
Laboratory **Hospital Facility** **Non Hospital Facility**	 100% covered after $80 copay; deductible does not apply 100% covered after $20 copay; deductible does not apply	 Not Covered Not Covered
Durable Medical Equipment, Orthotics and Prosthetics	80% covered; deductible does not apply	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	For organ transplants performed at Blue Distinction Centers for Transplants (BDCT), charges are covered at 100%, deductible does not apply. For transplants performed at participating but non-BDCT facilities, charges are covered at a reduced benefit level of 80% after deductible.	Not Covered
Precertification Requirements (4)	Yes	

Benefit	IN Network	Out-of-Network
Prescription Drugs **Administered by RX Benefits not Highmark Delaware** **Information available at www.express-scripts.com**	Retail (0–30-day supply) Generic Drugs $10 copay Preferred Brand Drugs $20 copay Non-Preferred $35 copay GLP1s for Weight Loss 20% Coinsurance Retail (31-90 supply) Maintenance Generic $10 Maintenance Preferred Brand $20 Maintenance non-preferred $35 Mail Order Extended Supply (0–90-day supply) Generic $10 copay Preferred Brand $20 copay Non-Preferred Brand$35 copay GLP1s for Weight Loss not available for Mail Order Some drugs require prior authorization and/or have quantity limits.	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) 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 expenses. 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 100% of the plan allowance for covered expenses, for the rest of the plan year.

(3) Services are limited to those listed on the Highmark Delaware Preventive Schedule.

(4) 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.

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.
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