Delaware River & Bay Authority – Client # 134009
Group #'s 10456772, 10456773, and 10456774

HIGHMARK. Delaware

Summary of HDHP EPO 100% $3,500/$5,500 *Benefits – January 2027*

This program is a Qualified High Deductible Plan (HDHP) as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). 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.

Benefit	Network
General Provisions	
Benefit Period(1)	Contract Year
Deductible (per benefit period) Embedded Individual Family	 $3,500 $5,500
Plan Pays – payment based on the plan allowance	100% after deductible
Out-of-Pocket Limit (Includes medical & prescription drug copayments. Once met, plan pays 100% of covered services for the rest of the benefit period.) Individual Family	 N/A
Total Maximum Out-of-Pocket (Includes deductible, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period Individual Family	 $5,000 $10,000
Office/Urgent Care Visits	
Primary Care Provider Office Visits & Virtual Visits	$15 copayment after deductible
Specialist Office Visits & Virtual Visits	$20 copayment after deductible
Virtual Visit Originating Site Fee	100% after deductible
Telemedicine	$15 copayment
Urgent Care Center Visits	100% after deductible
Preventive Care (3)	
Routine Adult 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 Medically Necessary	 100% (deductible does not apply) 100% after deductible
Diagnostic services and procedures	100% (deductible does not apply)
Routine Pediatric Physical exams	 100% (deductible does not apply)
Pediatric immunizations	100% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)
Vision Adult: Routine Vision Exam	Not Covered
Pediatric: Routine Vision Exam	Not Covered
Emergency Services	
Emergency Room Services	$150 copayment after deductible (copayment waived if admitted)
Ambulance	100% after deductible
Hospital and Medical/Surgical Expenses (including maternity)	
Hospital Inpatient	100% after deductible
Hospital Outpatient	100% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible
Medical Care (including inpatient visits and consultations)**/Surgical Expenses**	100% after deductible

Benefit	Network
Therapy and Rehabilitation Services	
Physical Therapy & Occupational Therapy	100% after deductible Physical therapy and occupational therapy are a combined 60 visit limit per benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse
Respiratory Therapy	100% after deductible
Speech Therapy	100% after deductible Limit: 60 visits per benefit period - Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse
Spinal Manipulations	100% after deductible Limit: 30 visits per benefit period
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible
Mental Health/Substance Abuse	
Inpatient Mental Health Services	100% after deductible
Inpatient Detoxification/Rehabilitation	100% after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	100% after deductible
Outpatient Substance Abuse	100% after deductible
Other Services	
Assisted Fertilization Procedures	$600 maximum benefit for Artificial Insemination
Allergy Extracts and Injections	100% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (4)	100% after deductible
Dental Services Related to Accidental Injury	100% after deductible
Diagnostic Services 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	100% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible
Home Health Care	100% after deductible Limit: 100 visits per benefit period; aggregate with Visiting Nurse
Hospice	100% after deductible
Private Duty Nursing	100% after deductible Limited to Inpatient Only - Covered up to 240 hours per benefit period
Skilled Nursing Facility Care	100% after deductible Limit: 120 days per confinement; benefits renew after 180 days without care
Transplant Services	100% after deductible
Precertification Requirements (5)	Yes
Prescription Drugs	
Prescription Drug Deductible Individual Family	Integrated with medical deductible Integrated with medical deductible

Benefit	Network
Administered by Rx Benefits not Highmark Delaware **Information available at www.express-scripts.com**	Applies to Deductible First, then Copay after Deductible is Met 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 20% Coinsurance Some drugs require prior authorization and/or have quantity limits.

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 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 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.
3) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
4) Coverage for eligible members to age 21. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
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 Deitsch schwetzscht, kannscht du en Dolmetscher griege, 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 આવેલા 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។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់របស់លោកអ្នក (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 yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ 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 మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दिनुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुनुछन्। तपाईको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

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).