State of Delaware: Highmark Comprehensive PPO

Coverage Period: 07/01/2025 - 06/30/2026

Coverage for: Individual + Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage you can visit **www.highmarkbcbsde.com** or call **1-844-459-6452**. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.highmarkbcbsde.com or call **1-844-459-6452** to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network provider: **$0**; Out-of- Network provider: **$300** individual/**$600** family.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Out-of-network anesthesia services covered in-network at network facilities, emergency ambulance, emergency paramedic and emergency physician services are covered before you meet your out-of-network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers preventive services, without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	Network provider Medical: **$4,500** individual/**$9,000** family; Network provider Prescription Drug: **$2,100** individual/ **$4,200** family. Out-of-Network provider Medical: **$7,500** individual/**$15,000** family; Out-of-Network provider Prescription Drug: Not Applicable	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Premiums, balance billing charges, health care this plan does not cover, copayments and coinsurance on certain services and penalties for failure to obtain preauthorization.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. See www.highmarkbcbsde.com, or call **1-844-459-6452** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	20% coinsurance	None
	Specialist visit	$30 copay/visit	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	20% coinsurance	Coverage is limited by age, gender, and risk parameters as identified in Highmark Delaware's Preventive Health Guidelines. Refer to www.highmarkbcbsde.com or call **1-844-459-6452** for specific information. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for x-ray at non-hospital affiliated freestanding facility; $50 copay/visit at hospital-based facilities $10 copay/visit at preferred freestanding lab; $50 copay/visit at other lab. No charge for machine tests.	20% coinsurance	Preferred freestanding laboratory: LabCorp and Quest Diagnostics in Delaware.

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
		No charge for mental health and substance abuse disorder at any in-network lab/facility.		
	Imaging (CT/PET scans, MRIs)	No charge at non-hospital affiliated freestanding facility; $100 copay/visit at hospital-based facilities. No charge for mental health and substance abuse disorder at any in-network facility.	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or call **833-458-0835 (toll-free)**	Generic drugs	$10 copay/prescription for 30-day supply (retail or mail order); $20 copay/prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in-network allowable amount minus applicable copay	Up to 30-day fills at retail or mail order for non-maintenance drugs; 90-day fills for maintenance drugs available at participating pharmacies or mail order only, maintenance drugs filled as 30-day supply incur penalty at fourth fill; under Choice Program, you pay applicable copay plus difference between generic and brand when preferred generic equivalent is available. Erectile dysfunction (ED) drugs are not covered unless medically necessary for conditions other than ED. Prescription drugs with an over-the-counter equivalent are not covered, except for emergency contraception. Qualified members ages 40 - 75 receive generic low to moderate dose statins at no cost. No charge for diabetic supplies purchased through the prescription plan. One copay applies for multiple diabetic medications filled at a 90-day participating retail pharmacy or mail order pharmacy, if purchased at the same time.
	Preferred brand drugs	$32 copay/prescription for 30-day supply (retail or mail order); $64 copay/prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in-network allowable amount minus applicable copay	
	Non-preferred brand drugs	$60 copay/prescription for 30-day supply (retail or mail order); $120 copay/prescription for 90-day supply (participating retail or mail order)	Reimbursement limited to in-network allowable amount minus applicable copay	

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Specialty drugs	No charge if enrolled in the PrudentRx program; 30% coinsurance if not enrolled in the PrudentRx program	Not covered	Specialty drugs must be filled by CVS Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay/visit outpatient hospital-affiliated facility; $50 copay/visit non-hospital affiliated ambulatory surgery center	20% coinsurance	Preauthorization is required for certain outpatient surgical procedures. If you don't get preauthorization, benefits will be denied. Additional benefits for non-emergency, planned surgeries are available through Lantern.
	Physician/surgeon fees	No charge	20% coinsurance	Preauthorization is required for certain outpatient surgical procedures. If you don't get preauthorization, benefits will be denied.
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit	In-network or out-of-network copayment is waived if admitted. Care must be rendered within 48 hours of onset of symptoms.
	Emergency medical transportation	$50 copay for air ambulance. *No charge for ground ambulance.*	$50 copay for air ambulance. *No charge for ground ambulance.* Deductible does not apply	None
	Urgent care	$20 copay/visit	20% coinsurance	Telemedicine is covered at $0 copay per visit when using Amwell for acute issues and behavioral health.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/day; $200 maximum/admission $100 copay/day; $200 maximum/admission for elective orthopedic & spine procedures performed at preferred Blue	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be denied. Copayments and coinsurance for bariatric surgery do not accumulate towards the out-of-pocket maximum. Additional benefits for non-emergency, planned surgeries are

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
		Distinction Centers (BDC) or $500 copay/admission at other facilities No charge for bariatric surgery through Lantern		available through Lantern. Bariatric surgeries are only covered through Lantern.
	Physician/surgeon fees	No charge	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for intensive outpatient care; $20 copay/office visit	20% coinsurance	None
	Inpatient services	$100 copay/day; $200 maximum/admission	20% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be denied.
If you are pregnant	Office visits	No charge	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the types of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	$100 copay/day; $200 maximum/admission	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Limited to 240 visits per plan year. Preauthorization is required. If you don't get preauthorization, benefits will be denied.
	Rehabilitation services	15% coinsurance 0% coinsurance for Physical, Occupational and Speech Therapy for mental health and substance abuse disorder diagnosis.	20% coinsurance	No charge for in-network applied behavioral analysis (ABA). Maximum number of Physical, Occupational and Speech Therapies is based on medical necessity.
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses.
	Skilled nursing care	No charge	20% coinsurance	Limited to 120 days of care. Benefits renew after 180 days without care. Preauthorization is required. If you don't get preauthorization, benefits will be denied.

State of Delaware: Highmark Comprehensive PPO

Common Medical Event	Services You May Need	What Will You Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Durable medical equipment	No charge	20% coinsurance	None
	Hospice services	No charge	20% coinsurance	Limited to 365 days of care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	You must pay 100% of these expenses. Coverage may be available through EyeMed Vision.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	No charge under Delta Dental or Dominion Dental	20% coinsurance under Delta Dental; not covered under Dominion Dental	Delta Dental: $1,500 maximum per person per plan year; Dominion Dental: no maximum.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Glasses
- Habilitation services
- Long-term care (non-hospice)
- Routine eye care (Adult)
- Routine foot care (unless medically necessary)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (only covered through Lantern)
- Chiropractic care (30 visits per plan year, except for treatment of back pain). *No charge for mental health and substance abuse disorder diagnosis for in-network, outpatient visits.*
- Dental care (bone fractures, removal of bony impacted teeth, tumors and orthogenic cysts; limited accidental injuries)
- Hearing aids (one hearing aid, per ear, every 3 years up to age 24)
- Infertility treatment (lifetime maximum: $30,000 medical and $15,000 prescription drug)
- Weight loss programs (nutritional counseling). *No charge for nutritional counseling for mental health and substance abuse disorders for in-network visits.*
- Non-emergency care when traveling outside the U.S
- Private-duty nursing (non-hospice; inpatient care in acute hospital setting; limited to 240 hours in a 12-month period)
- Employee assistance services through Health Advocate

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. You can also contact the plan at 1-844-459-6452. Other

coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Highmark Blue Cross Blue Shield Delaware at 1-844-459-6452 or www.highmarkbcbsde.com. Additionally, a consumer assistance program can help you file an appeal. Contact the Delaware Department of Insurance/Consumer Assistance Program, 841 Silver Lake Blvd., Dover, DE 19904 or 302-674-7300 (local), 1-800-282-8611 (toll free) or consumer@state.de.us.

Does this Coverage Provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this Coverage Meet the Minimum Value Standard? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Arabic (العربية): 1-800-489-8933 اتصل برقم .إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان
Chinese (繁體中文): 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-489-8933.
French (Français): Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-489-8933.
French Creole (Kreyòl Ayisyen): Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-489-8933.
German (Deutsch): Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 1-800-489-8933.
Italian (Italiano): In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-489-8933.
Japanese (日本語): 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-489-8933 まで、お電話にてご連絡ください。
Korean (한국어): 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-489-8933 번으로 전화해 주십시오.
Persian-Farsi (فارسی): اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-489-8933 تماس بگیرید
Polish (Polski): Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-489-8933.
Portuguese (Português): Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-489-8933.
Russian (Русский): Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-489-8933.
Spanish (Español): Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-489-8933.
Tagalog (Tagalog): Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-489-8933.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible:** $0
- **Specialist copayment:** $30
- **Hospital (facility) copayment:** $100 per day, Maximum $200 per admission
- **Obstetric care copay/coinsurance:** No charge

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$160**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible:** $0
- **Specialist copayment:** $30
- **Hospital (facility) copayment:** $100 per day, Maximum $200 per admission
- **Diagnostic test (blood work) copayment:** $10*

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$720**

Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

- **The plan's overall deductible:** $0
- **Specialist copayment:** $30
- **Hospital (facility) copayment:** $100 per day, Maximum $200 per admission
- **Diagnostic test (x-ray) copayment:** No charge**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$350**

* Assumes member elects a preferred lab.
**Assumes member elects a freestanding facility.

The plan would be responsible for the other costs of these EXAMPLE covered services.