New Castle County Government – Client # 134014
Active Employees Group # 10055811 & Pensioners U-65 Group # 10055812

HIGHMARK. Delaware

Summary of EPO *Benefits – January 2026*

Benefit	IN Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (**Embedded**) Individual Family	 N/A N/A	 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	 N/A N/A	 N/A N/A
Total Maximum Out of Pocket(2) **(Embedded)** (Medical In-Network deductible, coinsurance, and copays). Once met, plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $10,600 $18,400	 N/A N/A
Office/Clinic/Urgent Care Visits		
Primary Care Provider Office Visits	100% after $25 copayment; deductible does not apply	Not Covered
Specialist Office Visits	100% after $35 copayment; deductible does not apply	Not Covered
Urgent Care Center Visits	100% after $25 copayment; deductible does not apply	Not Covered
Preventive Care(3)		
Routine Adult(3) Physical exams Adult immunizations Colorectal cancer screening Routine gynecological exams, including a Pap Test Routine Mammogram Prostate Specific Antigen Test	 100% Covered 100% Covered 100% Covered 100% Covered 100% Covered 100% Covered	 Not Covered Not Covered Not Covered Not Covered Not Covered
Routine Pediatric Physical exams Pediatric immunizations	100% Covered 100% Covered 100% Covered	 Not Covered Not Covered
Vision Adult: Routine Vision Exam Pediatric Vision: Routine Vision Exam	 100% Covered One routine eye exam every 24 months 100% Covered One routine eye exam every 12 months	 Not Covered Not Covered
Hospital and Medical/Surgical Expenses (including Maternity)		
Hospital Inpatient	100% Covered	Not Covered
Hospital Outpatient	100% Covered	Not Covered
Maternity (non-preventive facility & professional services)	100% Covered	Not Covered
Medical/Surgical (except office visits)	100% Covered	Not Covered
Ambulatory Surgery	100% Covered	Not Covered
Emergency Services		
Emergency Room Services	100% after $100 copayment per visit (waived if admitted)	
Ambulance	100% after $25 copayment per occurrence	

Benefit	IN Network	Out-of-Network
Outpatient Therapy Rehabilitation Services		
Physical and Occupational Therapy	80% Covered	Not Covered
Speech Therapy	80% Covered	Not Covered
Chiropractic	80% Covered	Not Covered
	Limit: 30 visits/calendar year	
Cardiac Rehab	80% Covered	Not Covered
Chemotherapy and Radiation Therapy	100% Covered	Not Covered
Mental Health/Substance Abuse		
Inpatient	100% covered	Not Covered
Inpatient Detoxification/Rehabilitation	100% covered	Not Covered
Outpatient	100% covered	Not Covered
Other Services		
Diagnostic Services **Advanced Imaging (MRI, CAT, PET scan, etc.)**	100%; deductible does not apply	Not Covered
Standard Imaging (X-Rays, including diagnostic mammograms)	100%; deductible does not apply	Not Covered
Laboratory	100% Covered	Not Covered
Durable Medical Equipment, Prosthetics & Hearing Aids (1 hearing aid per impaired ear every 36 months)	80% Covered	Not Covered
Home Health Care	100% Covered	Not Covered
	Limit: 100 visits/calendar year	
Hospice	100% Covered for up to 240 days	Not Covered
Private Duty Nursing	100% Covered	Not Covered
	Limit: 240 hours/12-month period - Inpatient Only	
Skilled Nursing Facility Care	100% Covered	Not Covered
	Limit: 120 days/calendar year (in lieu of hospitalization)	
Infertility Services	Covered at applicable service's benefit; up to a $40,000 Lifetime Maximum	Not Covered
Prescription Drugs **Administered by ESI Direct not Highmark Delaware Information available at www.express-scripts.com**	Generic Drugs $8 copay Preferred Brand Drugs $30 copay Non-Preferred Brand Drugs $50 copay $20,000 Lifetime Maximum for Infertility Drugs	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 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 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.
All percentages are based on Highmark Blue Cross Blue Shield Delaware's allowable charge.