

## Delaware Valley SD 10213447, 10213448, 10213449, 10213450, 10213451, 01785020, 10213452, 10213453, 10213454

On the chart below, you'll see what your plan pays for specific services. 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	Hospital	Medical/Surgical	Major Medical
General Provisions			
Effective Date	January 1, 2025		
Benefit Period(1)	Calendar Year		
Deductible (per benefit period)			
Individual	none	none	\$250
Family	none	none	\$750
Plan Pays – payment based on the plan allowance	100%	100%	60% after deductible
Out-of-Pocket Limit ( Once met, plan pays100% coinsurance for the rest of the benefit period)			
Individual	none	none	\$400
Family	none	none	\$1,200
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) Once met, the plan pays 100% of covered services for the rest of the benefit period.			
Individual			
Family	not applicable		
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	not covered	not covered	60% after deductible
			60% after deductible.
Primary Care Provider Office Visits & Virtual Visits	not covered	not covered	Benefit maximum of 6 visits, per member, per benefit period for nutritional therapy not subject to deductible
			60% after deductible.
Specialist Office Visits & Virtual Visits	not covered	not covered	Benefit maximum of 6 visits, per member, per benefit period for nutritional therapy not subject to deductible
Virtual Visit Originating Site Fee	not covered	not covered	60% after deductible
Urgent Care Center Visits	not covered	not covered	60% after deductible
Telemedicine Services (2)	not covered	not covered	60% after deductible
Preventive Care (3)			
Routine Adult			
Physical Exams	100%	100%	60% after deductible
Adult Immunizations	100%	100%	60% after deductible
Routine Gynecological Exams	100%	100%	60% after deductible
Routine Pap Smear	100%	100%	60% after deductible
Breast Cancer Screenings (annual routine and supplemental)	100%	100%	60% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100%	100%	60% after deductible
Colorectal Cancer Screening	100%	100%	60% after deductible
Diagnostic Services and Procedures	100%	100%	60% after deductible
Prostate Cancer Screening	100%	100%	60% after deductible
Routine Pediatric			
Physical Exams	100%	100%	60% after deductible
Pediatric Immunizations	100%	100%	60% after deductible
Diagnostic Services and Procedures	100%	100%	60% after deductible
Emergency Services			
Emergency Accident (4)	100%	100%	60% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Emergency Medical (4)	100%	100%	60% after deductible
Ambulance	not covered	not covered	60% after deductible
<b>Hospital and Medical / Surgical Expenses (including maternity) (4)</b>			
Hospital Inpatient	100%	100%	60% after deductible
Hospital Outpatient	100%	not covered	60% after deductible
Outpatient Surgery (facility)	100%	not covered	60% after deductible
Surgical Services (professional)	not covered	100%	60% after deductible
Maternity (non-preventive facility & professional services)	100%	100%	60% after deductible
Maternity for Dependent Daughters	100%	100%	60% after deductible
Medical Care (including inpatient visits and consultations) / Surgical Expenses	not covered	100%	60% after deductible
<b>Therapy and Rehabilitation Services</b>			
Physical Medicine	100%	not covered	60% after deductible
Respiratory Therapy	100%	100%	60% after deductible
Speech Therapy	not covered	not covered	60% after deductible
Occupational Therapy	not covered	not covered	60% after deductible
Spinal Manipulations	not covered	not covered	60% after deductible
Cardiac Rehabilitation Therapy	not covered	not covered	60% after deductible benefit maximum of 36 visits, per 3 month period following a cardiac episode
Infusion Therapy	100%	not covered	60% after deductible
Chemotherapy	100%	100%	60% after deductible
Radiation Therapy	100%	100%	60% after deductible
Dialysis	not covered	not covered	60% after deductible
<b>Mental Health / Substance Abuse</b>			
Inpatient Mental Health Services	100%	100%	60% after deductible
Inpatient Substance Abuse Detoxification	100%	100%	60% after deductible
Inpatient Substance Abuse Rehabilitation	100%	100%	60% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	Not covered	Not covered	100% (deductible does not apply)
Outpatient Substance Abuse Services	100%	100%	60% after deductible
<b>Other Services</b>			
Allergy Extracts	not covered	100%	60% after deductible
Allergy Injections	not covered	100%	60% after deductible
Autism Spectrum Disorder Including Applied Behavior Analysis (5)	100%	100%	60% after deductible
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	not covered	not covered	not covered
Dental Services Related to Accidental Injury	100%	100%	60% after deductible
<b>Diabetes Treatment</b>			
Equipment and Supplies	not covered	not covered	60% after deductible
Diabetes Education Program	100%	not covered	60% after deductible
<b>Diagnostic Services</b>			
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	100%	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	100%	60% after deductible
Durable Medical Equipment, Supplies, Orthotics, and Prosthetics	not covered	not covered	60% after deductible
Home Health Care	100% benefit maximum of 100 visits per benefit period	100%	60% after deductible
Hospice	100% benefit maximum of \$8,000 per lifetime	100%	60% after deductible
Infertility Counseling, Testing	100%	100%	60% after deductible
Mammograms, Medically Necessary	100%	100%	60% after deductible

Benefit	Hospital	Medical/Surgical	Major Medical
Private Duty Nursing	not covered	not covered	60% after deductible benefit maximum of 240 hours, per benefit period
Skilled Nursing Facility Care	100%	100%	60% after deductible
Transplant Services	100%	100%	60% after deductible
Precertification Requirements (6)	Yes	No	No
<b>Prescription Drugs</b>			
Prescription Drug Deductible Individual Family	\$125 \$375		
Prescription Drug Out-of-Pocket Limit	\$200 per person		
Prescription Drug Program (7) Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.  Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	<b>Retail Drugs</b> 20% for Formulary brand drugs 20% for Non-Formulary brand drugs 20% for Formulary generic drugs 20% for Non-Formulary generic drugs  <b>Maintenance Drugs through Mail Order (90-day Supply)</b> 20% for Formulary brand drugs 20% for Non-Formulary brand drugs 20% for Formulary generic drugs 20% for Non-Formulary generic drugs		

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 benefits summary.

(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

(2) Telemedicine Services (acute care for minor illnesses available on-demand 24/7) must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).

(3) Services are limited to those listed on the Highmark Preventive Schedule with enhancements (Women's Health Preventive Schedule may apply).

(4) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.

(5) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services- Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category

(6) If you receive services from an out-of-area provider or a provider who does not participate with the local Blue Cross and/or Blue Shield plan, you must contact Highmark Utilization Management prior to a planned inpatient admission, or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.

(7) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Your plan requires that you use a specific specialty pharmacy for hemophilia medications. Please contact member services for more details. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary.

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield, First Priority Health or First Priority Life, all of which are independent licensees of the Blue Cross Blue Shield Association.

## 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 employer – and not the claims administrator – is entirely responsible for determining member eligibility and for the design of your plan/program; including, any exclusion or limitation described in the benefit Booklet.*

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，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 Deutsch schwetzsch, kannsch du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannsch du die Nummer an deine 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 المساعدة 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.

ધયાન 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).

પ્રકારઃ ઉપરોક્ત સેવાઓ માટે ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (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)。

توجہ: 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 yáńílti'go, language assistance services, éí t'áá níf'eh, bee níká a'doowol, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'déé' (TTY: 711) jì' hodiilnih.

ધયાન દે: यदि आप हनिदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दए 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, లాగిష్టిక అసిస్టిన్స్ సర్వీసెస్, ఛార్జి లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

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

ધયાન દનિહોસ: यदि तपाईं नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। तपाईंको आइडी कार्डको पछाडि आगमा 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).