New Castle County Government – Client # 134014
Pensioners U-65 Group # 10006174

Summary of Co-Op 80 *Benefits – January 2024*

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	Coverage
General Provisions	
Benefit Period	Calendar Year
Deductible (**Embedded)** Individual Family	 $200 $400
Plan Pays – payment based on the plan allowance	A percentage based on the benefit.
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	 $9,450 $18,900
Office/Clinic/Urgent Care Visits	
Primary Care Provider Office Visits	80% Covered after deductible
Specialist Office Visits	80% Covered after deductible
Urgent Care Center Visits	80% Covered after deductible
Preventive Care(1)	
Routine Adult Physical exams Adult immunizations Colorectal cancer screening Routine gynecological exams, including a Pap Test Routine Mammogram Prostate Specific Antigen (PSA) Screening	 100%; deductible does not apply 100%; deductible does not apply 100%; deductible does not apply 100%; deductible does not apply 100%; deductible does not apply 100%; deductible does not apply
Routine Pediatric Routine physical exams Pediatric immunizations	 100%; deductible does not apply 100%; deductible does not apply
Hospital and Medical/Surgical Expenses (including Maternity)	
Hospital Inpatient	100% after a $10 per day copay for first 7 days of each admission
Hospital Outpatient	100%; deductible does not apply
Outpatient Facility Visits – Non Surgical	100%; deductible does not apply
Maternity (facility services)	100% after a $10 per day copay for first 7 days of each admission
Maternity (professional services)	80%; deductible does not apply
Medical/Surgical Expenses (except office visits)	80%; deductible does not apply
Emergency Services	
Emergency Room Services	100%; deductible does not apply
Ambulance	100%; deductible does not apply
Therapy and Rehabilitation Services	
Physical and Occupational Therapy	100%; deductible does not apply
Speech Therapy	100%; deductible does not apply
Chiropractic –30 visits per calendar year maximum	80%; deductible does not apply
Cardiac Rehab	100%; deductible does not apply
Chemotherapy and Radiation Therapy	100%; deductible does not apply
Mental Health/Substance Abuse	
Inpatient and Day Hospital **Inpatient Detoxification/Rehabilitation**	100% after a $10 per day copay for first 7 days of each admission
Outpatient	80% Covered after deductible

Benefit	Coverage
Other Services	
Diagnostic Services **Advanced Imaging (MRI, CAT, PET scan, etc.)**	100%; deductible does not apply
Standard Imaging (X-Rays, including diagnostic mammograms)	100%; deductible does not apply
Laboratory	100%; deductible does not apply
Durable Medical Equipment, Prosthetics & Hearing Aids (1 hearing aid per impaired ear every 36 months)	80%; deductible does not apply
Home Health Care	100%; deductible does not apply; Limit: 240 visits per calendar year
Hospice	100%; deductible does not apply; Limit: 240 days
Private Duty Nursing	80%, deductible does not apply; Limit: 240 hours/12 month period – Inpatient Only
Skilled Nursing Facility Care	100%; deductible does not apply; Limit: 120 days
Infertility Services	Covered at applicable service's benefit; up to a $40,000 Lifetime Maximum
Prescription Drugs	80% Covered after Deductible $20,000 Lifetime Maximum for Infertility Drugs

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.

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.