New Castle County Government – Client # 134014
Active Employee Group # 10006182 & Pensioners U65 Group # 10006173

HIGHMARK. Delaware

Summary of Blue Choice PPO *Benefits – January 2020*

Benefit	IN Network	Out-of-Network
General Provisions		
Benefit Period(1)	Calendar Year	
Deductible (**Embedded**) Individual Family	 $200 (DME, Prosthetics, & Hearing Aids Only) $400 (DME, Prosthetics, & Hearing Aids Only)	 $200 $400
Plan Pays – payment based on the plan allowance	80% after deductible (For DME, Prosthetics, & Hearing Aids Only)	80% covered after deductible
Coinsurance Maximum (Embedded) (per benefit period) Individual Family	 $2,000 (DME, Prosthetics, & Hearing Aids Only) $4,000 (DME, Prosthetics, & Hearing Aids Only)	 $2,000 $4,000
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 calendar year. Individual Family	 $8,150 $16,300	 N/A N/A
Office/Clinic/Urgent Care Visits		
Primary Care Provider Office Visits	100% after $15 copayment; deductible does not apply	80% covered after deductible
Specialist Office Visits	100% after $25 copayment; deductible does not apply	80% covered after deductible
Urgent Care Center Visits	100% after $25 copayment; deductible does not apply	80% covered after deductible
Preventive Care(3)		
Routine Adult[3]		
Physical exams	100%; deductible does not apply	Not Covered
Adult immunizations	100%; deductible does not apply	Not Covered
Colorectal cancer screening	100%; deductible does not apply	Not Covered
Routine gynecological exams, including a Pap Test	100%; deductible does not apply	Not Covered (except PAP @ 100%)
Routine Mammogram	100%; deductible does not apply	Not Covered
Prostate Specific Antigen Test	100%; deductible does not apply	
Routine Pediatric	100%; deductible does not apply	
Physical exams	100%; deductible does not apply	Not Covered
Pediatric immunizations	100%; deductible does not apply	Not Covered
Vision Adult: Routine Vision Exam Pediatric Vision: Routine Vision Exam	 100% covered; deductible does not apply One routine eye exam every 24 months 100% covered; deductible does not apply One routine eye exam every 12 months	 Not Covered Not Covered
Hospital and Medical/Surgical Expenses (including Maternity)		
Hospital Inpatient	100% Covered	80% covered after deductible
Hospital Outpatient	100% Covered (Diagnostic Imaging - $10 Copay)	80% covered after deductible
Maternity (non-preventive facility & professional services)	100% Covered	80% covered after deductible
Medical/Surgical (except office visits)	100% Covered	80% covered after deductible
Ambulatory Surgery	100% Covered	80% covered after deductible
Emergency Services		
Emergency Room Services	100% after $50 copayment per visit (waived if admitted)	
Ambulance	100% Covered	

Benefit	IN Network	Out-of-Network
Outpatient Therapy Rehabilitation Services		
Physical and Occupational Therapy	100% Covered	80% covered after deductible
Speech Therapy	100% Covered	80% covered after deductible
Chiropractic	80% Covered	80% covered after deductible
	Limit: 30 visits/benefit period	
Cardiac Rehab	100% Covered	80% covered after deductible
Chemotherapy and Radiation Therapy	100% Covered	80% covered after deductible
Mental Health/Substance Abuse		
Inpatient	100% Covered	80% covered after deductible
Inpatient Detoxification/Rehabilitation	100% Covered	80% covered after deductible
Outpatient	100% Covered	80% covered after deductible
Other Services		
Diagnostic Services **Advanced Imaging (MRI, CAT, PET scan, etc.)**	100% covered after $10 copayment	80% covered after deductible
Standard Imaging (X-Rays, including diagnostic mammograms)	100% covered after $10 copayment	80% covered after deductible
Laboratory	100% Covered	80% covered after deductible
Durable Medical Equipment, Prosthetics & Hearing Aids (1 hearing aid per impaired ear every 36 months)	80% covered after deductible	80% covered after deductible
Home Health Care	100% Covered	100% Covered
	Limit: 240 visits/calendar year	
Hospice	100% Covered	100% Covered
Private Duty Nursing	100% Covered	80% covered after deductible
	Limit: 240 hours/12-month period - Inpatient Only	
Skilled Nursing Facility Care	100% Covered	100% Covered
	Limit: 120 days/calendar year	
Infertility Services (Counseling, Testing and Treatment)	Covered at applicable service's benefit; up to a $40,000 Lifetime Maximum; combined with Assisted Fertilization Procedure Lifetime Max; Combined In and Out of Network	Covered at applicable service's benefit; up to a $40,000 Lifetime Maximum; combined with Assisted Fertilization Procedure Lifetime Max and Combined In and Out of Network
Assisted Fertilization Procedures	Covered at applicable service's benefit; up to a $40,000 Lifetime Maximum; combined with Infertility Services Lifetime Max; Combined In and Out Of Network	Covered at applicable service's benefit; up to a $40,000 Lifetime Maximum; combined with Infertility Services Lifetime Max; Combined In and Out of Network
Prescription Drugs **Administered by ESI Direct not Highmark Delaware Information available at www.express-scripts.com**	Generic Drugs $5 copay Preferred Brand Drugs $15 copay Non-Preferred Brand Drugs $30 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.

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.