HIGHMARK. Delaware

University of Delaware Student Health Insurance Plan

On the chart below, you'll see what your PPO plan pays for specific services.

Benefit	In-Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year – *August 15, 2014 – August 14, 2015*	
Deductible (per benefit period) Individual Family	 $50 $100	 $100 $200
Plan Pays – payment based on the plan allowance	80% after deductible	60% after deductible
Out-of-Pocket Maximum (includes deductible, coinsurance and copays) Once met, plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $2,000 $4,000	 $4,000 $8,000
Office/Clinic/Urgent Care Visits		
Primary Care Provider Office Visits	100% after $20 copayment (deductible does not apply)	60% after deductible
Specialist Office Visits	100% after $20 copayment (deductible does not apply)	60% after deductible
Urgent Care Center Visits	100% after $20 copayment (deductible does not apply)	60% after deductible
Preventive Care(2) (3)		
Routine Adult		
Physical exams	100% (deductible does not apply)	60% after deductible
Adult immunizations	100% (deductible does not apply)	60% after deductible
Colorectal cancer screening	100% (deductible does not apply)	60% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	60% (deductible does not apply)
Mammograms, annual routine	100% (deductible does not apply)	60% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Routine adult vision exam once every 24-months	100% (deductible does not apply)	60% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	60% after deductible
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Pediatric vision exam (including dilation, as professionally indicated)(3)	100% (deductible does not apply)	60% after deductible
Pediatric frame selection(3)	100% (deductible does not apply)	60% after deductible
Standard eyeglass lenses (per pair)(3)	100% (deductible does not apply)	60% after deductible
Pediatric dental exam and cleanings(3)	100% (deductible does not apply)	60% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient & Outpatient **Maternity** (non-preventive facility & professional services) **Medical services** **Surgery** (inpatient and outpatient)	80% after deductible	60% after deductible
Emergency Services		
Emergency Room Services	No deductible; 100% after $100 copayment (waived if admitted)	
Ambulance	80% after deductible	
Therapy and Rehabilitation Services		
Physical & Occupational Therapy	100% after $20 copayment (deductible does not apply)	60% after deductible
	Limit: 30 visits per contract year combined for each rehabilitation and habilitation	
Respiratory Therapy	80% after deductible	60% after deductible
Chiropractic	80% after deductible	75% after deductible
	Limit: 30 visits per contract year	
Speech Therapy	100% after $20 copayment (deductible does not apply)	60% after deductible
	Limit: 30 visits per contract year for each rehabilitation and habilitation	
Other Therapy Services Cardiac Rehab (Covered up to 3 sessions per week and 3 months of treatment), Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis	80% after deductible	60% after deductible

Benefit	In-Network	Out-of-Network
Mental Health/Substance Abuse		
Inpatient **Inpatient Detoxification/Rehabilitation**	80% after deductible	60% after deductible
Mental Health Outpatient	100% after $20 copayment (deductible does not apply)	60% after deductible
Substance Abuse Outpatient	100% after $20 copayment (deductible does not apply)	60% after deductible
Other Services		
Diagnostic Services **Advanced Imaging (MRI, CAT, PET scan, etc.)**	80% after deductible	60% after deductible
Standard Imaging (including diagnostic mammograms)	80% after deductible	60% after deductible
Laboratory	80% after deductible	60% after deductible
Assisted Fertilization Procedures	Not Covered	
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible
Home Health Care (Limit: 120 days per contract year)	80% after deductible	60% after deductible
Hospice	80% after deductible	60% after deductible
Oral Surgery	$20 specialist office visit copay; 80% after deductible - outpatient hospital (subject to medical review)	60% after deductible
Private Duty Nursing (Limit: 240 hours/benefit period – Inpatient Only)	80% after deductible	60% after deductible
Skilled Nursing Facility Care **(Benefit Maximum: 120 days per confinement benefits renew after 180 days without care)**	80% after deductible	60% after deductible
Transplant Services	80% after deductible BDCT Preferred coverage for organ transplants performed at the Blue Distinction Centers for Transplants. For transplants performed at participating but non-BDCT facilities charges are covered at a reduced benefit level. (20% less than INN) Member Cost-Sharing accumulates to OOP	Not Covered
Prescription Drugs		
Prescription Drug Program(4) Mandatory Generic *Defined by the Premier Pharmacy Network. Prescriptions filled at a non-network pharmacy are not covered.* • *Generic Drug Copayment* • *Formulary Brand Drug Copayment* • *Non-Formulary Drug Copayment* *Your plan uses the Comprehensive Formulary.*	**Retail Drugs and Mail Order** **(Up to a 34 day supply /35-90-day supply)** $10.00/$20.00 $20.00/$40.00 $40.00/$80.00	Not Covered

(1) Your group's benefit period is based on a Plan Year. The Plan Year is a consecutive 12-month period. Your Plan Year period runs from August 15, 2014 through August 14, 2015.
(2) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
(3) Pediatric vision and dental benefits are only available for dependent children or health care members under age 19.
(4) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. To obtain a prescription medication that is not included on this formulary, your provider must complete the 'Prescription Drug Medication Request Form' and return it to the Pharmacy Affairs Department for clinical review. Under the mandatory generic provision, you are responsible for the payment differential when a generic drug is available and you specify a brand name drug. Your payment is the price difference between the brand name drug and the generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

When calculating deductible or coinsurance expenses, only the allowable charges are considered. All percentages listed above apply to Highmark Delaware's allowable charge.
This Benefits Summary presents plan highlights only. It is not a contract. Contract limitations and exclusions apply. Please refer to your benefits booklet or contract for complete information.