University of Delaware PPO Blue Student Health Insurance Plan

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	Network	Out-of-Network
General Provisions		
Benefit Period(1)	Contract Year	
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 Limit (includes deductible and coinsurance; excludes copayments and prescription drug cost sharing) Once met, the plan pays 100% of covered medical and pediatric dental services for the rest of the benefit period. Individual Family	 None None	 $4,000 $8,000
Total Maximum Out-of-Pocket(2) (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	 $4,000 $8,000	 Not Applicable Not Applicable
Office/Urgent Care Visits		
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after $20 copayment One copayment per day, per provider	60% after deductible
Specialist Office Visits & Virtual Visits	100% after $20 copayment One copayment per day, per provider	60% after deductible
Urgent Care Center Visits	100% after $50 copayment One copayment per day, per provider	60% after deductible
	Copayment, if any, does not apply to visits for the treatment of Mental Health or Substance Abuse	
Telemedicine Services(3)	100% after $20 copayment One copayment per day, per provider	Not Covered
Preventive Care(4)		
Routine Adult Physical exams	 100% (deductible does not apply)	 60% after deductible
Adult immunizations	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 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
Adult: Routine Vision Exam (Administered by Davis Vision)	100% (deductible does not apply) 1 examination (including refraction) every 12 months	Not Covered
Pediatric Vision(5) Exam (including dilation as professional indicated)	 100% (deductible does not apply)	 Not Covered
Frames	100% (deductible does not apply)	Not Covered
Lenses	100% (deductible does not apply)	Not Covered

Benefit	Network	Out-of-Network
Pediatric Dental(5) Routine Exam, X-rays, Cleanings, Consultations, Fluoride Treatments, Palliative Treatment (emergency), Sealants and Space Maintainers	100% (deductible does not apply)	Not Covered
Other Pediatric Dental Services(6)	50% (deductible does not apply)	Not Covered
Emergency Services		
Emergency Room Services(7)	100% after $100 copayment (copayment waived if admitted)	
Ambulance(8)	80% after network deductible	
Hospital and Medical/Surgical Expenses(7)		
Hospital Inpatient	80% after deductible	60% after deductible
Hospital Outpatient (Non-Surgical)	80% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	60% after deductible
Maternity (non-preventive facility & professional services)	80% after deductible	60% after deductible
Medical Care (including inpatient visits and consultations)	80% after deductible	60% after deductible
Therapy and Rehabilitation Services		
Physical Therapy & Occupational Therapy	100% after $10 copayment One copayment per day, per provider	75% after deductible
	Benefit Limit: Unlimited visit limit per benefit period each for Habilitative and Rehabilitative;	
Speech Therapy	100% after $10 copayment One copayment per day, per provider	60% after deductible
	Benefit Limit: Unlimited visit limit per benefit period each for Habilitative and Rehabilitative;	
Spinal Manipulations	80% after deductible	75% after deductible
	Benefit Limit: Unlimited visits per benefit period;	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy, Respiratory Therapy and Dialysis)	80% after deductible	60% after deductible
Mental Health/Substance Abuse		
Inpatient Mental Health Services	80% after deductible	60% after deductible
Inpatient Detoxification/Rehabilitation	80% after deductible	60% after deductible
Outpatient Mental Health Services - Includes Virtual Behavioral Health Visits	100% after $10 copayment One copayment per day, per provider	60% after deductible
Outpatient Substance Abuse	100% after $10 copayment One copayment per day, per provider	60% after deductible
Other Services		
Allergy Extracts and Injections	100% after $20 copayment One copayment per day, per provider	60% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder(9)	80% after deductible	60% after deductible
Dental Services Related to Accidental Injury	80% after deductible; or if performed in physician office, only PCP or Specialist copayment applies, then 100% One copayment per day, per provider	60% after deductible
Diagnostic Services	Copayments, if any, do not apply to Diagnostic Services prescribed for the treatment of Mental Health or Substance Abuse	
Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	60% after deductible
Standard Imaging	80% after deductible	60% after deductible
Diagnostic Medical	80% after deductible	60% after deductible
Pathology/Laboratory	80% after deductible	60% after deductible
Allergy Testing	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics (excludes foot orthotics)	80% after deductible; 100% (deductible does not apply) for insulin infusion pumps	60% after deductible
Hearing Aids	80% after deductible	60% after deductible
	Benefit Limit: One hearing aid per ear, per year for persons less than 24 years of age	
Home Health Care	80% after deductible	60% after deductible
	Benefit Limit: 100 visits per benefit period, aggregate with Visiting Nurse	
Hospice	80% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment	80% after deductible	60% after deductible

Benefit	Network	Out-of-Network
Private Duty Nursing	80% after deductible	60% after deductible
	Benefit Limit: Limited to Inpatient Only - Covered up to 240 hours per benefit period	
Skilled Nursing Facility Care	80% after deductible	60% after deductible
	Benefit Limit: 120 days per confinement; benefits renew after 180 days without care	
Transplant Services	100% after deductible for services received at a BDC (Blue Distinction Center) facility; 80% after deductible for services received at non-BDC facilities	60% after deductible
Precertification/Authorization Requirements(10)	Yes	
Prescription Drugs		
Prescription Drug Deductible Individual Family	None None	
Prescription Drug Program(11) Soft Mandatory Generic Defined by the National Plus 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.	**Retail Drugs (34/90-day Supply)** $15 / $30 generic copayment $40 / $80 formulary brand copayment $60 / $120 non-formulary brand copayment 30% coinsurance for tier 4 and 5 specialties. Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a month supply **Maintenance Drugs through Mail Order (34/90-day Supply)** $15 / $30 generic copayment $40 / $80 formulary brand copayment $60 / $120 non-formulary brand copayment 30% coinsurance for tier 4 and 5 specialties. Cost-sharing for Prescription Insulin Drugs will not exceed $100 for a month supply	

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 benefit summary.

1. Your group's benefit period is based on a Contract Year, a twelve month consecutive period from August 15, 2024 through August 14, 2025.
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.
3. 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. Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
4. Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
5. Pediatric vision and dental benefits are only available to dependent children or health plan members under age 19.
6. Includes Medically Necessary orthodontic services which are part of an approved orthodontic plan intended to treat a severe dentofacial abnormality. Prior approval is required.
7. 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.
8. Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.
9. After initial evaluation, Applied Behavioral Analysis 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 (e.g. speech therapy, diagnostic services). Treatment for Autism Spectrum Disorders does not reduce visit/day limits.
10. Precertification or preauthorization requirements may apply to certain inpatient admissions, outpatient procedures, or covered services (including covered medications).
11. 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 their cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed. Your plan requires that you use a specific specialty pharmacy for hemophilia medications. Please contact member services for more details. 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.