

## Summary of PPOBlue Benefits

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Provider (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period. *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.*

### Susquehanna University \$500 Deductible

Benefit	Network	Out-of-Network
<b>Benefit Period</b> <sup>(1)</sup>	Contract Year	
<b>Deductible</b> (per benefit period)		
Individual	\$500	\$1,000
Family	\$1,000	\$2,000
<b>Plan Payment Level</b> – Based on the provider's reasonable charge (PRC)	100% after deductible	80% after deductible
<b>Out-of-Pocket Maximums</b> (Once met, plan payment level becomes 100%)		
Individual	None	\$3,000
Family	None	\$6,000
<b>Lifetime Maximum</b> (per person)	Unlimited	
<b>Primary Care Provider Office Visits</b>	100% after \$20 copayment	80% after deductible
<b>Specialist Office Visits</b>	100% after \$20 copayment	80% after deductible
<b>Preventive Care</b> <sup>(2)</sup>		
<b>Routine Adult</b>		
Physical exams	100% (deductible does not apply)	80% after deductible
Adult immunizations	100% (deductible does not apply)	80% after deductible
Colorectal cancer screening	100% (deductible does not apply)	80% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	80% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
<b>Routine Pediatric</b>		
Physical exams	100% (deductible does not apply)	80% after deductible
Pediatric immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
<b>Emergency Room Services</b>	100% after \$50 copayment (waived if admitted)	
<b>Spinal Manipulations</b>	100% after \$20 copayment	80% after deductible
	Limit: 20 visits/benefit period	
<b>Physical Medicine</b>	100% after \$20 copayment	80% after deductible
	Limit: 30 visits/benefit period	
<b>Speech Therapy</b>	100% after \$20 copayment	80% after deductible
	Limit: 30 visits/benefit period	
<b>Occupational Therapy</b>	100% after \$20 copayment	80% after deductible
	Limit: 30 visits/benefit period	
<b>Allergy Extracts and Injections</b>	100% after deductible	80% after deductible
<b>Ambulance</b>	100% after deductible	80% after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Dental Services Related to Accidental Injury</b>	Not Covered	
<b>Diabetes Treatment</b>	100% after deductible	80% after deductible
<b>Diagnostic Services</b>		
<i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100% after deductible	80% after deductible
<b>Enteral Formulae</b>	100% (deductible does not apply)	80% (deductible does not apply)
<b>Home Infusion Therapy</b>	100% after deductible	80% after deductible

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Home Health Care</b>	100% after deductible	80% after deductible
	Limit: 90 visits/benefit period	
<b>Hospice</b>	100% after deductible	80% after deductible
<b>Hospital Services</b>		
Inpatient	100% after deductible	80% after deductible
Outpatient	100% after deductible	80% after deductible
<b>Infertility Counseling, Testing and Treatment<sup>(3)</sup></b>	100% after deductible	80% after deductible
<b>Maternity</b> (facility & professional services)	100% after deductible	80% after deductible
<b>Medical/Surgical Expenses</b> (except office visits)	100% after deductible	80% after deductible
<b>Mental Health</b>		
Inpatient	100% after deductible	80% after deductible
Outpatient	100% after \$20 copayment	80% after deductible
<b>Private Duty Nursing</b>	100% after deductible	80% after deductible
	Limit: 240 hours/benefit period	
<b>Respiratory Therapy</b>	100% after deductible	80% after deductible
<b>Skilled Nursing Facility Care</b>	100% after deductible	80% after deductible
	Limit: 100 days/benefit period	
<b>Substance Abuse</b>		
Inpatient Detoxification	100% after deductible	80% after deductible
Inpatient Rehabilitation	100% after deductible	80% after deductible
Outpatient	100% after \$20 copayment	80% after deductible
<b>Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
<b>Transplant Services</b>	100% after deductible	80% after deductible
<b>Precertification Requirements<sup>(4)</sup></b>	Yes	
<b>Prescription Drug Deductible</b>		
Individual	None	
Family	None	
<b>Premier Prescription Drug Program</b> Mandatory Generic <sup>(5)</sup> <i>Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>	<b>Retail Drugs (31-day Supply)</b> \$10 generic copayment \$20 brand copayment \$35 non-formulary brand copayment  <b>Maintenance Drugs through Mail Order (90-day Supply)</b> \$25 generic copayment \$50 brand copayment \$85 non-formulary brand copayment	

## Questions? Call Member Services at **1-800-345-3806**

[www.highmarkblueshield.com](http://www.highmarkblueshield.com)

- (1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
- (2) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
- (3) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (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 not, you are responsible for contacting MM&P. 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.
- (5) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. You are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

*This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.*