

# Summary of Benefits

## Qualified High Deductible Health Plan (HDHP)

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). This program should not be combined with any funding arrangement other than an HSA.

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. **If you enroll as an individual, the deductible and out-of-pocket maximums for the "Employee Only Plan" apply. If you enroll as a family, the deductible and out-of-pocket maximums for the "Family Plan" apply and can be satisfied by one or more of your family members.** 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 - HDHP

Benefit	Network	Out-of-Network
<b>Benefit Period</b> <sup>(1)</sup>	Contract Year	
<b>Deductible per benefit period</b> (Applies to Medical and Prescription Drug benefits) Employee Only Plan Family Plan	\$1,500 Combined \$3,000 Combined	
<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> (Includes prescription drug expenses, coinsurance and copayments. Once met, plan payment level becomes 100%) Employee Only Plan Family Plan	None None	\$3,000 \$6,000
<b>Lifetime Maximum</b> (per person)	Unlimited	
<b>Primary Care Provider Office Visits</b>	100% after deductible	80% after deductible
<b>Specialist Office Visits</b>	100% after deductible	80% after deductible
<b>Preventive Care</b> <sup>(3)</sup> <i>Routine Adult</i> 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	Routine: 100% (deductible does not apply) Medically Necessary: 100% after deductible	80% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	80% after deductible
<i>Routine Pediatric</i> 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>Urgent Care Center Visits</b>	100% after deductible	80% after deductible
<b>Emergency Room Services</b>	100% after deductible	
<b>Spinal Manipulations</b>	100% after deductible Limit: 20 visits/benefit period	80% after deductible
<b>Physical Medicine</b>	100% after deductible Limit: 30 visits/benefit period	80% after deductible
<b>Speech Therapy</b>	100% after deductible Limit: 30 visits/benefit period	80% after deductible
<b>Occupational Therapy</b>	100% after deductible Limit: 30 visits/benefit period	80% after deductible
<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>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<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% after deductible	80% after deductible
<b>Home Infusion Therapy</b>	100% after deductible	80% after deductible
<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>(4)</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 deductible	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 deductible	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>(5)</sup></b>	Yes	
<b>Prescription Drug Deductible</b>		
Individual	Integrated with medical deductible	
Family	Integrated with medical deductible	
<b>Premier Prescription Drug Program</b> <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> Plan pays 100% after deductible  <b>Maintenance Drugs through Mail Order (90-day Supply)</b> Plan pays 100% after deductible	

**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.
- (5) 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.
- (6) At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled.

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

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