

Summary of EPOBlue Benefits



An EPO, or Exclusive Provider Organization, offers one level of benefits. Except for emergencies, all covered services must be received from an EPO network provider. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period.

Susquehanna University

Benefit	Coverage
Benefit Period ⁽¹⁾	Contract Year
Deductible (per benefit period)	
Individual	None
Family	None
Plan Payment Level – Based on the provider’s reasonable charge (PRC)	100%
Out-of-Pocket Maximums (Once met, plan payment level becomes 100%)	
Individual	None
Family	None
Lifetime Maximum (per person)	Unlimited
Primary Care Physician Office Visits	100% after \$20 copayment
Specialist Office Visits	100% after \$20 copayment
Preventive Care	
<i>Adult</i>	
Routine physical exams	100% after \$20 copayment
Adult Immunizations	100%
Colorectal Cancer Screening	
Basic Diagnostic Services	100%
Medical Surgical	100%
Routine gynecological exams, including a Pap Test	100% after \$20 copayment
Mammograms, annual routine and medically necessary	100%
<i>Pediatric</i>	
Routine physical exams	100% after \$20 copayment
Pediatric immunizations	100%
Emergency Room Services	100% after \$50 copayment (waived if admitted)
Spinal Manipulations	100% after \$20 copayment Limit: 20 visits/benefit period
Physical Medicine	100% after \$20 copayment Limit: 30 visits/benefit period
Speech Therapy	100% after \$20 copayment Limit: 30 visits/benefit period
Occupational Therapy	100% after \$20 copayment Limit: 30 visits/benefit period
Allergy Extracts and Injections	100%
Ambulance	100%
Assisted Fertilization Procedures	Not Covered
Dental Services Related to Accidental Injury	Not Covered
Diabetes Treatment	100%
Diagnostic Services (including routine)	
<i>Advanced Imaging</i> (MRI, CAT Scan, PET scan, etc.)	100%
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%
Durable Medical Equipment, Orthotics and Prosthetics	100%
Enteral Formulae	100%
Home Infusion Therapy	100%
Home Health Care	100% Limit: 100 visits/benefit period
Hospice	100%
Hospital Services – Inpatient	100%
Hospital Services – Outpatient	100%
Infertility Counseling, Testing and Treatment ⁽²⁾	100%
Maternity (facility & professional services)	100%
Medical/Surgical Expenses (except office visits)	100%

Benefit	Coverage
Mental Health – Inpatient (3)	100%
Mental Health – Outpatient (3)	100% after \$20 copayment
Private Duty Nursing	100% Limit: 240 hours/benefit period
Respiratory Therapy	100%
Skilled Nursing Facility Care	100% Limit: 60 days/benefit period
Substance Abuse	
Inpatient Detoxification	100%
Inpatient Rehabilitation	100%
Outpatient	100%
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%
Transplant Services	100%
Precertification Requirements (4)	Yes
Prescription Drug Deductible	
Individual	None
Family	None
Premier Prescription Drug Program	Retail Drugs (31-day Supply)
Mandatory Generic(5)	\$10 generic copayment
<i>Defined by Premier Pharmacy Network - Not Physician Network.</i>	\$20 brand copayment
<i>Prescriptions filled at a non-network pharmacy are not covered.</i>	\$35 non-formulary brand copayment
	Maintenance Drugs through Mail Order (90-day Supply)
	\$25 generic copayment
	\$50 brand copayment
	\$85 non-formulary brand copayment

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

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- (1) Your group's benefit period is based on Contract Year. The Contract Year is a 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
- (2) 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.
- (3) State mandated minimum benefits may apply to a diagnosis of serious mental illness. (If the above grid does not show a limit, your mental health benefit days and visits are unlimited.)
- (4) Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. 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 doctor 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.