

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 Physician (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period.

Susquehanna University

Benefit	Network	Out-of-Network
Benefit Period (1)	Contract Year	
Deductible (per benefit period)		
Individual	None	\$200
Family	None	\$400
Plan Payment Level – Based on the provider's reasonable charge (PRC)	100%	80% after deductible
Out-of-Pocket Maximums (Once met, plan payment level becomes 100%)		
Individual	None	\$3,000
Family	None	\$6,000
Lifetime Maximum (per person)	Unlimited	
Primary Care Physician Office Visits	100% after \$20 copayment	80% after deductible
Specialist Office Visits	100% after \$20 copayment	80% after deductible
Preventive Care		
<i>Adult</i>		\$400 benefit period maximum
Routine physical exams	100% after \$20 copayment	80% after deductible
Adult Immunizations	100%	80% after deductible
Colorectal Cancer Screening		
Diagnostic Services	100%	80% after deductible
Medical Surgical	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100% after \$20 copayment	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	80% after deductible
<i>Pediatric</i>		
Routine physical exams	100% after \$20 copayment	80% after deductible
Pediatric immunizations	100%	80% (deductible does not apply)
Emergency Room Services	100% after \$50 copayment (waived if admitted)	
Spinal Manipulations	100% after \$20 copayment	80% after deductible
	Limit: 20 visits/benefit period	
Physical Medicine	100% after \$20 copayment	80% after deductible
	Limit: 30 visits/benefit period	
Speech Therapy	100% after \$20 copayment	80% after deductible
	Limit: 30 visits/benefit period	
Occupational Therapy	100% after \$20 copayment	80% after deductible
	Limit: 30 visits/benefit period	
Allergy Extracts and Injections	100%	80% after deductible
Ambulance	100%	80% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	Not Covered	
Diabetes Treatment	100%	80% after deductible
Diagnostic Services (including routine)		
<i>Advanced Imaging</i> (MRI, CAT Scan, PET scan, etc.)	100%	80% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible
Enteral Formulae		80% (deductible does not apply)
Home Infusion Therapy	100%	80% after deductible
Home Health Care	100%	80% after deductible
	Limit: 90 visits/benefit period	

Benefit	Network	Out-of-Network
Hospice	100%	80% after deductible
Hospital Services – Inpatient	100%	80% after deductible
Hospital Services – Outpatient	100%	80% after deductible
Infertility Counseling, Testing and Treatment⁽²⁾	100%	80% after deductible
Maternity (facility & professional services)	100%	80% after deductible
Medical/Surgical Expenses (except office visits)	100%	80% after deductible
Mental Health – Inpatient (3)	100%	80% after deductible
Mental Health – Outpatient (3)	100% after \$20 copayment	80% after deductible
Private Duty Nursing	100%	80% after deductible
	Limit: 240 hours/benefit period	
Respiratory Therapy	100%	80% after deductible
Skilled Nursing Facility Care	100%	80% after deductible
	Limit: 100 days/benefit period	
Substance Abuse		
Inpatient Detoxification	100%	80% after deductible
Inpatient Rehabilitation	100%	80% after deductible
Outpatient	100%	80% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
Transplant Services	100%	80% after deductible
Precertification Requirements⁽⁴⁾	Yes	
Prescription Drug Deductible		
Individual	None	
Family	None	
Premier Prescription Drug Program Mandatory Generic ⁽⁵⁾ <i>Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>	Retail Drugs (31-day Supply) \$10 generic copayment \$20 brand copayment \$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 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) 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.