

**Penn State**  
**PPOBlue Benefit Summary**



PAYMENT LEVEL	IN-NETWORK DEDUCTIBLE	OFFICE VISITS	EMERGENCY ROOM SERVICES
100%/80%	\$0/\$0	\$10/\$15 COPAY	\$50 COPAY

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, 100% of the Provider's Reasonable Charge. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. You will be responsible for paying the difference between the out-of-network payment and the out-of-network provider's charge. In either case, you coordinate your 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.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Benefit Period</b>	Contract Year <i>Twelve consecutive months beginning on the contract date</i>	
<b>Deductible Per Benefit Period</b>	None	\$500 Individual \$1,000 Family Aggregate
<b>Payment Level</b> <i>Based on Provider's Reasonable Charge (PRC)</i>	100% PRC	80% PRC after deductible until out-of-pocket limit is met; then 100% PRC
<b>Out-of-Pocket Limit</b> <i>Includes Coinsurance, certain exclusions may apply</i>	Not Applicable	\$2,000 Individual \$4,000 Family Aggregate
<b>Lifetime Maximum</b>	Unlimited	\$500,000/person
<b>Ambulance</b>	100% PRC	80% PRC after deductible
<b>Assisted Fertilization Procedures</b> <i>(Artificial Insemination Only)</i>	100% PRC	80% PRC after deductible
	----- \$2,500 maximum per lifetime	
<b>Dental Services Related to an Accidental Injury</b>	100% PRC	80% PRC after deductible
	----- Limited to surgery within 24 hours of accident	
<b>Diabetes Treatment</b>	100% PRC	80% PRC after deductible
<b>Diagnostic Services</b> <i>Lab, X-ray, and Medical Tests</i>	100% PRC	80% PRC after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100% PRC	80% PRC after deductible
<b>Emergency Room Services</b>	100% PRC after \$50 Copay – waived if admitted	
<b>Hearing Care Services</b>	100% PRC	
	----- Limited to \$700 per 36 months for the purchase of a hearing aid device and audiometric testing	
<b>Home Health Care</b> <i>Excludes Respite Care</i>	100% PRC	80% PRC after deductible
	----- 120 visits/benefit period	
<b>Hospice</b> <i>Includes Respite Care</i>	100% PRC	80% PRC after deductible
<b>Hospital Expenses</b> <i>Inpatient and Outpatient</i>	100% PRC	80% PRC after deductible
<b>Infertility Counseling, Testing and Treatment</b> <i>Treatment includes coverage for the correction of a physical or medical problem associated with infertility.</i>	100% PRC	80% PRC after deductible
<b>Maternity</b> <i>Includes Dependent Daughters</i>	100% PRC	80% PRC after deductible
<b>Medical Care</b> <i>Includes Inpatient Visits and Consultations</i>	100% PRC	80% PRC after deductible
<b>Mental Health Inpatient</b> ①	100% PRC	80% PRC after deductible
	----- 30 days/benefit period (up to 30 for serious mental illness)	
<b>Mental Health Outpatient</b> ① <i>Includes services provided by licensed social workers and licensed professional counselors</i>	100% PRC after \$15 Copay	50% PRC after deductible
	----- 30 visits/benefit period (up to 60 for serious mental illness)	
<b>Occupational Therapy</b> <i>Outpatient</i>	100% PRC after \$15 Copay	80% PRC after deductible
	----- 24 visits/benefit period	
<b>Office Visits</b> <i>Primary Care Physician</i>	100% PRC after \$10 Copay	80% PRC after deductible
<i>Specialty Care Physician</i>	100% PRC after \$15 Copay	80% PRC after deductible

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100%/80%	\$0/\$0	\$10/\$15 COPAY	\$50 COPAY
BENEFITS		IN-NETWORK	OUT-OF-NETWORK
<b>Oral Surgery</b>		100% PRC	80% PRC after deductible
<b>Physical Medicine</b> <i>Outpatient</i>		100% PRC after \$15 Copay 24 visits/benefit period	80% PRC after deductible
<b>Preventive Care</b> <i>Adult Preventive Care Schedule includes:</i> <i>Routine Physical Exam</i> <i>Immunizations</i> <i>Routine Diagnostic Screening</i> <i>Screening Mammography</i> <i>Routine Gynecological Exam &amp; Pap Test</i>		100% PRC after \$10 Copay 100% PRC 100% PRC 100% PRC 100% PRC after \$15 Copay	80% PRC after deductible 80% PRC after deductible 80% PRC after deductible 80% PRC after deductible 80% PRC no deductible/lifetime maximum
<i>Pediatric Preventive Care Schedule includes:</i> <i>Routine Physical Exams</i> <i>Pediatric Immunizations</i>  <i>Routine Diagnostic Screening</i>		100% PRC after \$10 Copay 100% PRC  100% PRC	80% PRC after deductible 80% PRC no deductible/lifetime maximum  80% PRC after deductible
<i>Highmark's preventive care schedule is updated periodically based on changes in clinical practice guidelines.</i>			
<b>Private Duty Nursing</b>		100% PRC 240 hours/benefit period	80% PRC after deductible
<b>Skilled Nursing Facility Care</b>		100% PRC 100 days/benefit period	80% PRC after deductible
<b>Speech Therapy</b> <i>Outpatient</i>		100% PRC after \$15 Copay 24 visits/benefit period	80% PRC after deductible
<b>Spinal Manipulations</b> <i>Outpatient</i>		100% PRC after \$15 Copay 24 visits/benefit period	80% PRC after deductible
<b>Substance Abuse Detoxification</b>		100% PRC 7 days/admission; 4 admissions/lifetime	80% PRC after deductible
<b>Substance Abuse Inpatient Rehabilitation</b>		100% PRC 30 days/benefit period; 90 days/lifetime	80% PRC after deductible
<b>Substance Abuse Outpatient</b>		100% PRC after \$15 Copay 60 visits/benefit period; 120 visits/lifetime	80% PRC after deductible
<b>Surgical Expenses</b> <i>Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, and Neonatal Circumcision</i>		100% PRC	80% PRC after deductible
<b>Gastric Bypass/Bariatric Surgery</b>		100% PRC	Not Covered
<b>Therapy and Rehabilitation Services</b> <i>Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy</i>		100% PRC	80% PRC after deductible
<b>Transplant Services</b>		100% PRC	Not Covered
<b>Wigs</b> <i>Cancer diagnosis only</i>		100% PRC after deductible \$300 maximum per lifetime	
<b>Precertification Requirements for Inpatient Admissions</b> <i>No Penalty for Non-compliance. If Highmark Blue Shield is not contacted prior to a non-emergency out-of-network inpatient admission and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the member will be responsible for any costs not covered.</i>		Performed by Network Provider	Performed by Member
<b>Condition Management</b>		Case Management, Blues on Call, and Disease State Management	

① State mandated benefits (30 inpatient days and 60 outpatient visits annually) **may** apply for serious diagnosis. Serious diagnosis includes schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder.



**Penn State**  
**Prescription Drug Card Program**  
**Incentive Option - Summary of Benefits**

PRESCRIPTION DRUG	RETAIL PHARMACY Including University Health Services Pharmacy	MAIL SERVICE PHARMACY Including University Health Services Pharmacy
<b>Deductible</b>	None	None
<b>Prescription Drug - Prescription Drug Card</b> <i>Retail 31 day supply; Mail Order 90 day supply</i>  <i>Specialty Medications-Will use Highmark's Specialty Tier for cost share assignment. Will require the use of Medmark exclusive.</i>	<b>Member pays:</b> 50% Coinsurance for Generic/50% Coinsurance for Brand Formulary/70% Coinsurance for Non-Formulary	<b>Member pays:</b> 20% Coinsurance for Generic/20% Coinsurance for Brand Formulary/70% Coinsurance for Brand Non-Formulary
	<b>Member pays:</b> 50% Coinsurance with a maximum copayment of \$50 per prescription for Specialty Rx on the formulary - 70% with a maximum copayment of \$100 per prescription for Specialty Rx not on the formulary.	Not covered, Medmark only.
<b>Formulary</b>	Three tier	
<b>Generic Substitution</b>	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 medically necessary	
<b>Out-of-Pocket Maximum</b>	\$1,000 per member	
<b>Claim Submission</b>	Pharmacy Files at Point-of-Sale	
<b>Non-Network Pharmacy</b>	Not Covered	
<b>PRESCRIPTION DRUG CATEGORIES</b>		
<b>Contraceptives (oral and injectable)</b>	Covered	
<b>Fertility Agents</b>	Not Covered	
<b>Fluoride Products</b>	Covered	
<b>Weight Loss Drugs</b>	Covered	
<b>Insulin and Diabetic Supplies</b>	Covered	
<b>Tobacco Deterrents</b> <i>(prescription and over the counter)</i>	Covered Covers gum, inhalers, patches, nasal spray and oral drugs specifically targeted at tobacco cessation \$300 maximum per person/benefit period	
<b>CARE MANAGEMENT PROGRAMS</b>		
<b>Exclusive Pharmacy Provider-Medmark</b> <i>30 day supply</i>	Selected high cost prescription drugs are covered only when they are dispensed through an exclusive pharmacy provider.	
<b>Quantity Level Limits</b> <i>on select prescription drugs</i>	The quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines.	
<b>Managed Rx Coverage</b> <i>on certain drug therapies</i>	Certain drug therapies may be monitored for appropriate usage and subject to case evaluation if recommended guidelines are exceeded.	
<b>Managed Prior Authorizations</b>	Select drugs may need prior authorization.	

**MEMBER SERVICE # 1-800-914-4384**  
**www.highmarkblueshield.com**