

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

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BENEFITS		IN-NETWORK	OUT-OF-NETWORK
Office Visits <i>Primary Care Physician</i> <i>Specialty Care Physician</i>		100% PRC after \$10 Copay 100% PRC after \$15 Copay	80% PRC after deductible 80% PRC after deductible
Oral Surgery		100% PRC	80% PRC after deductible
Physical Medicine <i>Outpatient</i>		100% PRC after \$15 Copay	80% PRC after deductible
Preventive Care <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 & 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>			
Private Duty Nursing		100% PRC	80% PRC after deductible
Skilled Nursing Facility Care		100% PRC	80% PRC after deductible
Speech Therapy <i>Outpatient</i>		100% PRC after \$15 Copay	80% PRC after deductible
Spinal Manipulations <i>Outpatient</i>		100% PRC after \$15 Copay	80% PRC after deductible
Substance Abuse <i>Detoxification</i>		100% PRC	80% PRC after deductible
Substance Abuse <i>Inpatient Rehabilitation</i>		100% PRC	80% PRC after deductible
Substance Abuse <i>Outpatient</i>		100% PRC after \$15 Copay	80% PRC after deductible
Surgical Expenses <i>Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, and Neonatal Circumcision</i>		100% PRC	80% PRC after deductible
Gastric Bypass/Bariatric Surgery		100% PRC	Not Covered
Therapy and Rehabilitation Services <i>Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy</i>		100% PRC	80% PRC after deductible
Transplant Services		100% PRC	Not Covered
Wigs <i>Cancer diagnosis only</i>		100% PRC after deductible \$300 maximum per lifetime	
Precertification Requirements for Inpatient Admissions <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
Condition Management		Case Management, Blues on Call, and Disease State Management	

① Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g., speech therapy). Treatment of autism spectrum disorders does not reduce visit/day limits.

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
Deductible	None	None
Prescription Drug - Prescription Drug Card <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>	Member pays: 50% Coinsurance for Generic/50% Coinsurance for Brand Formulary/70% Coinsurance for Non-Formulary	Member pays: 20% Coinsurance for Generic/20% Coinsurance for Brand Formulary/70% Coinsurance for Brand Non-Formulary
	Member pays: 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.
Formulary	Three tier	
Generic Substitution	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	
Out-of-Pocket Maximum	\$1,000 per member	
Claim Submission	Pharmacy Files at Point-of-Sale	
Non-Network Pharmacy	Not Covered	
PRESCRIPTION DRUG CATEGORIES		
Contraceptives (oral and injectable)	Covered	
Fertility Agents	Not Covered	
Fluoride Products	Covered	
Weight Loss Drugs	Covered	
Insulin and Diabetic Supplies	Covered	
Tobacco Deterrents <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	
CARE MANAGEMENT PROGRAMS		
Exclusive Pharmacy Provider-Medmark <i>30 day supply</i>	Selected high cost prescription drugs are covered only when they are dispensed through an exclusive pharmacy provider.	
Quantity Level Limits on select prescription drugs	The quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines.	
Managed Rx Coverage on certain drug therapies	Certain drug therapies may be monitored for appropriate usage and subject to case evaluation if recommended guidelines are exceeded.	
Managed Prior Authorizations	Select drugs may need prior authorization.	

MEMBER SERVICE # 1-800-914-4384
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