

# 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.

## Mercyhurst College

## Standard Design

Benefit	Network	Out-of-Network
<b>Benefit Period</b> <sup>(1)</sup>	Contract Year	
<b>Deductible</b> (per benefit period)	<i>Deductibles combined in and out of the network</i>	
Individual		\$350
Family		\$700
<b>Plan Payment Level</b> – Based on the provider's reasonable charge (PRC)	80% after deductible	50% after deductible
<b>Out-of-Pocket Maximums</b> (Once met, plan payment level becomes 100%)	<i>Out of pocket maximums combined in and out of the network</i>	
Individual		\$3,000
Family		\$6,000
<b>Lifetime Maximum</b> (per person)	\$1,000,000 (excluded prescription drug)	
<b>Primary Care Physician Office Visits</b>	100% after \$20 copayment*	50% after deductible
<b>Specialist Office Visits</b>	100% after \$40 copayment*	50% after deductible
<b>Preventive Care</b>		
<i>Adult</i>		
Routine physical exams	100% after \$20 copayment*	Not covered
Adult Immunizations	100% after \$20 copayment*	50% (deductible does not apply)
Therapeutic Injections	100% after \$20 copayment*	50% after deductible
Routine gynecological exams, including a Pap Test	100% after \$40 copayment* (maximums do not apply)	50% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	50% after deductible
<i>Pediatric</i>		
Routine physical exams	100% after \$20 copayment*	Not covered
Pediatric immunizations	100% after \$20 copayment* (maximums do not apply)	50% (deductible/maximums do not apply)
<b>Emergency Room Services</b>	80% after \$100 copayment (copayment waived if admitted)	
<b>Spinal Manipulations</b>	80% after deductible	50% after deductible
	Limit: 25 visits/benefit period	
<b>Physical Medicine</b>	80% after deductible	50% after deductible
	Limit: 25 visits/benefit period	
<b>Speech Therapy</b>	80% after deductible	50% after deductible
	Limit: 25 visits/benefit period	
<b>Occupational Therapy</b>	80% after deductible	50% after deductible
	Limit: 25 visits/benefit period	
<b>Allergy Extracts and Injections</b>	80% after deductible	50% after deductible
<b>Ambulance</b>	80% after deductible	
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Dental Services Related to Accidental Injury</b>	80% after deductible	50% after deductible
<b>Diabetes Treatment</b>	80% after deductible	50% after deductible
<b>Diagnostic Services (including routine)</b>		
<i>Advanced Imaging</i> (MRI, CAT Scan, PET scan, etc.)	80% after deductible	50% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	50% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	80% after deductible	50% after deductible
<b>Enteral Formulae</b>	80% (deductible does not apply)	50% (deductible does not apply)
<b>Home Infusion Therapy</b>	80% after deductible	50% after deductible
<b>Home Health Care</b>	80% after deductible	50% after deductible
<b>Hospice</b>	80% after deductible	50% after deductible
<b>Hospital Services – Inpatient</b>	80% after deductible	50% after deductible

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Hospital Services – Outpatient</b>	80% after deductible	50% after deductible
<b>Infertility Counseling, Testing and Treatment<sup>(2)</sup></b>	80% after deductible	50% after deductible
<b>Maternity</b> (facility & professional services)	80% after deductible	50% after deductible
<b>Medical/Surgical Expenses</b> (Except Office Visits)	80% after deductible	50% after deductible
<b>Mental Health – Inpatient<sup>(3)</sup></b>	80% up to out-of-pocket; 100% thereafter	50% up to out-of-pocket; 100% thereafter
<b>Mental Health – Outpatient<sup>(3)</sup></b>	80% up to out-of-pocket; 100% thereafter	50% up to out-of-pocket; 100% thereafter
<b>Private Duty Nursing</b>	80% after deductible	
<b>Respiratory Therapy</b>	80% after deductible	50% after deductible
<b>Skilled Nursing Facility Care</b>	80% after deductible	50% after deductible Limit: 60 days/benefit period
<b>Substance Abuse – Inpatient Detoxification</b>	80% up to out-of-pocket; 100% thereafter Limit: 7 days/admission; 4 admissions/lifetime	50% up to out-of-pocket; 100% thereafter
<b>Substance Abuse – Inpatient Rehabilitation</b>	80% up to out-of-pocket; 100% thereafter Limit: 30 days/benefit period; 90 days/lifetime	50% up to out-of-pocket; 100% thereafter
<b>Substance Abuse – Outpatient</b>	80% up to out-of-pocket; 100% thereafter Limit: 60 visits/benefit period; 120 visits/lifetime	50% up to out-of-pocket; 100% thereafter
<b>Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	50% after deductible
<b>Transplant Services</b>	80% after deductible	50% after deductible
<b>Precertification Requirements<sup>(4)</sup></b>	Yes	
<b>Premier Prescription Drug Program</b>	<p><b>Defined by Premier Gold Pharmacy Network - Not Physician Network.</b>  <b>(Prescriptions filled at a non-network pharmacy are not covered.)</b></p> <p><b>Retail Drugs</b>  \$10 generic copayment  \$25 brand formulary copayment  \$40 brand non-formulary copayment</p> <p><b>Mandatory Generic<sup>(5)</sup></b>  <b>31-day Supply</b></p> <p><b>Maintenance Drugs through Mail Order</b>  \$20 generic copayment  \$50 brand formulary copayment  \$80 brand non-formulary copayment</p> <p><b>Mandatory Generic<sup>(5)</sup></b>  <b>90-day Supply</b></p>	

\* Services are not subject to the in network contract year deductible.

Copayments do not apply towards the in network or out of network deductibles or out of pocket expenses.

- (1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your university'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 benefits (30 inpatient days and 60 outpatient visits annually with the right to exchange inpatient days for outpatient visits on a one-for-two basis) may apply to a diagnosis of serious mental illness. Serious mental illnesses include: schizophrenia, schizo-affective disorder, major depressive disorder, bipolar disorder, obsessive compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa, delusional disorder. Once mental health limits are exhausted, both inpatient and outpatient serious mental illness services must be provided by a network provider (see above-referenced benefits for plan limits).
- (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 & 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 elect to 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.

#### Mercyhurst College 2010 Standard Plan Rates

<b>ONLY USD Accepted</b>	<b><u>Individual</u></b>	<b><u>2 Person</u></b>	<b><u>Family</u></b>
<b>Annual Premium</b>	\$1,224.00	\$3,185.00	\$3,804.00
<b>By Trimester</b>	\$416.00	\$1,070.00	\$1,277.00

*This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program. 5/2008 – 05/21/08 rjp*