

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.

Allegheny College

Effective 07/01/2011

Benefit	Network	Out-of-Network
Benefit Period (1)	Calendar Year	
Deductible (per benefit period)		
Individual	None	\$250
Family	None	\$500
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	\$1,000
Family	None	\$2,000
Lifetime Maximum (per person)	Unlimited	
Autism Spectrum Disorders Maximum (per person)(2)	\$36,000/benefit period	
Primary Care Physician Office Visits	100% after \$20 copayment	80% after deductible
Specialist Office Visits	100% after \$20 copayment	80% after deductible
Preventive Care – Highmark Preventive Schedule		
<i>Adult</i>		
Routine physical exams	100%	Not Covered
Adult Immunizations	100%	80% after deductible
Colorectal cancer screening	100%	80% after deductible
Routine gynecological exams, including a Pap Test	100%	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100%	80% after deductible
Diagnostic services and procedures	100%	80% after deductible
<i>Pediatric</i>		
Routine physical exams	100%	Not Covered
Pediatric immunizations	100%	80% (deductible does not apply)
Diagnostic services and procedures	100%	80% after deductible
Emergency Room Services	100% after \$35 copayment (waived if admitted)	
Spinal Manipulations	100% after \$20 copayment	80% after deductible
	Limit: 20 visits/benefit period	
Physical Medicine - Outpatient	100% after \$10 copayment	80% after deductible
Speech Therapy - Outpatient	100% after \$10 copayment	80% after deductible
Occupational Therapy - Outpatient	100% after \$10 copayment	80% after deductible
Allergy Extracts and Injections	100%	80% after deductible
Ambulance	100%	
Assisted Fertilization Procedures (3)	100%	80% after deductible
	<i>Excludes coverage for invitro fertilization and/or artificial insemination procedures.</i>	
Dental Services Related to Accidental Injury	100%	80% after deductible
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	100%	80% (deductible does not apply)
Home Infusion Therapy	100%	
Home Health Care	100%	80% after deductible
Hospice	100%	80% after deductible

Benefit	Network	Out-of-Network
Hospital Services – Inpatient <i>Includes inpatient physical medicine, speech therapy and occupation therapy services.</i>	100%	80% after deductible
Hospital Services – Outpatient	100%	80% after deductible
Infertility Counseling, Testing & 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	100%	80% after deductible
Mental Health – Outpatient	100%	80% after deductible
Private Duty Nursing	100%	
Respiratory Therapy	100%	
Skilled Nursing Facility Care	100%	80% after deductible
Substance Abuse – Inpatient Detoxification	100%	80% after deductible
Substance Abuse – Inpatient Rehabilitation	100%	80% after deductible
Substance Abuse – 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
Pre-existing Condition Clause	No	
Precertification Requirements⁽⁴⁾	Yes	
Premier Prescription Drug Program Mandatory Generic⁽⁵⁾ <i>Premier Gold Pharmacy Network - not physician network. Prescriptions filled at a non-network pharmacy are not covered.</i>	<p align="center">Retail Drugs \$10 generic copayment \$20 brand formulary copayment \$40 brand non-formulary copayment 34-day Supply</p> <p align="center">Maintenance Drugs through Mail Order \$20 generic copayment \$40 brand formulary copayment \$80 brand non-formulary copayment 90-day Supply</p>	

**Customer Service Representatives are available Monday – Friday 8a-5p EST
1-800-241-5704**

- (1) Your group's benefit period is based on a Calendar Year. The Calendar Year runs from January 1st through December 31st.
- (2) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
- (3) 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. Excludes coverage for services related to in-vitro fertilization and artificial insemination.
- (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 prescription drug 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 prescription drug plan covers medications that are and are not on the formulary at the applicable copayments listed above. You are responsible for the payment differential when a generic drug is available and you request a brand name drug without the written authorization from the physician. 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. Selected over-the-counter medications are only covered with a written prescription for the select medication. Please contact Highmark Customer Service for additional information on the selected over-the-counter medications covered under the plan.

Additional information pertaining to your health insurance:

Act 4 is a Pennsylvania law that requires insurers to offer insured groups the option of covering dependents up to age 30. These dependents must meet certain guidelines set forth by the State of Pennsylvania. Please contact the Office of Human Resources at Allegheny College for information and guidelines.

Michelle's Law was enacted to provide coverage, for a period of up to one year, to dependent students who are required to take a medically necessary leave of absence (or other change in enrollment) from a post-secondary educational institution. For additional information and requirements, please contact the Office of Human Resources at Allegheny College.

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.
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