

## Moravian College (Choice – PPO 250-500)

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.

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Benefit Period</b> (1)	Contract Year	
<b>Deductible</b> (per benefit period)		
Individual	\$250	\$500
Family	\$500	\$1,000
<b>Plan Payment Level</b> – Based on the provider's reasonable charge (PRC)	100% after deductible	80% after deductible
<b>Out-of-Pocket Maximums</b> (Once met, plan payment level becomes 100%)		
Individual	None	\$2,500
Family	None	\$5,000
<b>Lifetime Maximum</b> (per person)	Unlimited	
<b>Primary Care Physician Office Visits</b>	100% after \$25 copayment	80% after deductible
<b>Specialist Office Visits</b>	100% after \$35 copayment	80% after deductible
<b>Preventive Care</b>		
<i>Adult</i>		
Routine physical exams	100% after \$25 copayment	80% after deductible
Adult Immunizations	100% after deductible	80% after deductible
Colorectal Cancer Screening		
Diagnostic Services	100% after deductible	80% after deductible
Medical Surgical	100% after deductible	80% after deductible
Routine gynecological exams, including a Pap Test	100% after \$35 copayment	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	80% no deductible
<i>Pediatric</i>		
Routine physical exams	100% after \$25 copayment	80% after deductible
Pediatric immunizations	100% (deductible does not apply)	80% (deductible does not apply)
<b>Emergency Room Services</b>	100% after \$75 copayment (waived if admitted)	
<b>Spinal Manipulations</b>	100% after \$35 copayment	80% after deductible
<b>Physical Medicine</b>	100% after \$35 copayment	80% after deductible
<b>Speech Therapy</b>	100% after \$35 copayment	80% after deductible
<b>Occupational Therapy</b>	100% after \$35 copayment	80% after deductible
<b>Allergy Extracts and Injections</b>	100% after deductible	80% after deductible
<b>Ambulance</b>	100% after deductible	80% after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Dental Services Related to Accidental Injury</b>	100% after deductible	80% after deductible
<b>Diabetes Treatment</b>	100% after deductible	80% after deductible
<b>Diagnostic Services</b> (including routine)		
<i>Advanced Imaging</i> (MRI, CAT Scan, PET scan, etc.)	100% after deductible	80% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100% after deductible	80% after deductible
<b>Enteral Formulae</b>	100% (deductible does not apply)	80% (deductible does not apply)
<b>Home Infusion Therapy</b>	100% after deductible	80% after deductible
<b>Home Health Care</b>	100% after deductible	80% after deductible
	Limit: 90 visits/benefit period	
<b>Hospice</b>	100% after deductible	80% after deductible
<b>Hospital Services – Inpatient</b>	100% after deductible	80% after deductible
<b>Hospital Services – Outpatient</b>	100% after deductible	80% after deductible
<b>Infertility Counseling, Testing and Treatment</b> (3)	100% after deductible	80% after deductible
<b>Maternity</b> (facility & professional services)	100% after deductible	80% after deductible

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Medical/Surgical Expenses</b> (except office visits)	100% after deductible	80% after deductible
<b>Mental Health – Inpatient</b>	100% after deductible	80% after deductible
<b>Mental Health – Outpatient</b>	100% after \$35 copayment	80% after deductible
<b>Private Duty Nursing</b>	100% after deductible	80% after deductible
	Limit: 240 hours/benefit period	
<b>Respiratory Therapy</b>	100% after deductible	80% after deductible
<b>Skilled Nursing Facility Care</b>	100% after deductible	80% after deductible
	Limit: 100 days/benefit period	
<b>Substance Abuse</b>		
Inpatient Detoxification	100% after deductible	80% after deductible
Inpatient Rehabilitation	100% after deductible	80% after deductible
Outpatient	100% after \$35 copayment	80% after deductible
<b>Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
<b>Transplant Services</b>	100% after deductible	80% after deductible
<b>Precertification Requirements</b> <sup>(4)</sup>	Yes	
<b>Prescription Drug Deductible</b>		
Individual	None	
Family	None	
<b>Premier Prescription Drug Program Deductible</b>	<b>Retail Drugs (31-day Supply)</b>	
	<b>\$100 per member</b>	
	\$10 generic copayment	
	\$30 brand copayment	
	\$60 non-formulary brand copayment	
	<b>Maintenance Drugs through Mail Order (90-day Supply)</b>	
	\$20 generic copayment	
	\$40 brand copayment	
	\$80 non-formulary brand copayment	
Mandatory Generic <sup>(5)</sup> <i>Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>		
<i>Mandatory Mail Order for maintenance medications</i>		

- (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) 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.
- (4) 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. . When a generic drug is available and a brand drug is dispensed, the member owes the difference in cost between the brand and generic drug in addition to the applicable brand drug copay or coinsurance. This applies regardless of the physician's directions on the prescription order.