

## Summary of PPO 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.

<b>Chatham University</b>	<b>2010-2011</b>	<b>016093-01</b>
<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 Family	\$250 \$500	\$500 \$1000
<b>Plan Payment Level</b> – Based on the provider's reasonable charge (PRC)	80% after deductible	60% after deductible
<b>Lifetime Maximum</b> (per person)	\$250,000	
<b>Primary Care Physician Office Visits</b>	100% after \$30 copayment	60% after deductible
<b>Specialist Office Visits</b>	100% after \$30 copayment	60% after deductible
<b>Preventive Care</b>		
<i>Adult</i>		
Routine physical exams	100% after \$30 copayment	Not Covered
Adult Immunizations	80%, after deductible	60%, after deductible
Routine gynecological exams, including a Pap Test	100% after \$30 copayment	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	60% after deductible
<i>Pediatric</i>	100% after \$30 copayment	Not Covered
Routine physical exams		
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
<b>Emergency Room Services</b>	100% after \$100 copayment (waived if admitted)	
<b>Spinal Manipulations</b>	100% after \$30 copayment	60% after deductible
<b>Physical Medicine</b>	100% after \$30 copayment	60% after deductible
<b>Speech Therapy</b>		
<b>Occupational Therapy</b>	Limit: Combined 25 visits/benefit period	
<b>Allergy Extracts and Injections</b>	80%, after deductible	60%, after deductible
<b>Ambulance</b>	80% after network deductible, not to exceed \$500 per trip	
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Dental Services Related to Accidental Injury</b>	80% after deductible	60% after deductible
<b>Diabetes Treatment</b>	80% after deductible	60% after deductible
<b>Diagnostic Services (including routine)</b>	80% after deductible	60% after deductible
<i>Advanced Imaging</i> (MRI, CAT Scan, PET scan, etc.)		
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	80% after deductible	60% after deductible
<b>Enteral Formulae</b>	80%, deductible does not apply	60%, deductible does not apply
<b>Home Infusion Therapy</b>	80% after network deductible 30 visit maximum/\$10,000 lifetime maximum	

<b>Home Health Care</b>	80% after deductible	60% after deductible
<b>Hospice</b>	80%, after deductible	60%, after deductible
<b>Hospital Services – Inpatient</b>	80% after deductible	60% after deductible
<b>Hospital Services – Outpatient</b>	80% after deductible	60% after deductible
<b>Infertility Counseling, Testing and Treatment<sup>(2)</sup></b>	80%, after deductible	60%, after deductible
<b>Maternity</b> (facility & professional services)	80% after deductible	60% after deductible
<b>Medical/Surgical Expenses</b> (Except Office Visits)	80% after deductible	60% after deductible
<b>Mental Health – Inpatient<sup>(3)</sup></b>	80% after deductible Limit: 30 days/benefit period	60% after deductible Limit: 10 days/benefit period
<b>Mental Health – Outpatient<sup>(3)</sup></b>	100% after \$30 copayment Limit: 20 visits/benefit period	60% after deductible Limit: 10 visits/benefit period
<b>Private Duty Nursing</b>	80% after network deductible, \$5,000 maximum per benefit period	
<b>Respiratory Therapy</b>	80% after network deductible	
<b>Skilled Nursing Facility Care</b>	80% after deductible	60% after deductible Limit: 100 days/benefit period
<b>Substance Abuse – Inpatient Detoxification</b>	80% after deductible	60% after deductible
<b>Substance Abuse – Inpatient Rehabilitation</b>	80% after deductible	60% after deductible
<b>Substance Abuse – Outpatient</b>	100% after \$30 copayment	60% after deductible
<b>Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
<b>Transplant Services</b>	80% after deductible	60% after deductible
<b>Precertification Requirements<sup>(4)</sup></b>	Yes	
<b>Premier Prescription Drug Program</b> 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>	<b>Retail Drugs (31-day Supply)</b> \$15 Generic \$25 Formulary Brand \$40 Non-Formulary Brand  <b>Maintenance Drugs through Mail Order (90-day Supply)</b> \$30 Generic  \$50 Formulary Brand \$80 Non-Formulary Brand	
	<b>Annual Maximum per contract period \$1000.00</b> Per each covered member	

# **Questions? Call 1-800-215-7865**

**Reference Code: P0010709**

*(Please have your Reference Code ready when you call)*

- (1) Your group's benefit period is based on a Contract Year .
- (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) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. To obtain a prescription medication that is not included on this formulary, your doctor must complete the 'Prescription Drug Medication Request Form' and return it to the Pharmacy Affairs Department for clinical review. Under the mandatory generic provision, you are responsible for the payment differential when a generic drug is available and you or your doctor specifies a brand name drug. Your payment is the price difference between the brand name drug and the generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.