

## 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.

### California University Student Health Plan

### 15546-01 Standard

| Benefit   | Network  | Out-of-Network                         |
|---|--|--|
| <b>Benefit Period</b> (1)   | Contract Year  |  |
| <b>Deductible</b> (per benefit period)  |  |  |
| Individual  | \$250  |  |
| Family  | \$500  |  |
| <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%)                               |  |  |
| Individual  | \$1,500  |  |
| Family  | \$3,000  |  |
| <b>Lifetime Maximum</b> (per person)  | \$1,000,000 (excluded prescription drug)   |  |
| <b>Primary Care Physician Office Visits</b>   | 80% after deductible   | 50% after deductible                   |
| <b>Specialist Office Visits</b>   | 80% after deductible   | 50% after deductible                   |
| <b>Preventive Care</b>  | Routine Diagnostic test done in conjunction with routine physical exam, must follow the Highmark preventative schedule, will reimburse at 100%, not subject to deductible or coinsurance |  |
| <i>Adult</i>  |  |  |
| Routine physical exams  | 100% after \$20 copayment  | 50% after deductible                   |
| 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 \$20 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  | 50% after deductible                   |
| Pediatric immunizations   | 100% after \$20 copayment (maximums do not apply)  | 50% (deductible/maximums do not apply) |
| <b>Emergency Room Services</b>  | 80% after \$50 copay, deductible applies   |  |
| <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>Benefit</b>  | <b>Network</b>   | <b>Out-of-Network</b>                                 |
|---|--|---|
| <b>Hospital Services – Inpatient</b>  | 80% after deductible   | 50% after deductible                                  |
| <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><br>(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<br>Limit: 60 days/benefit period |
| <b>Substance Abuse – Inpatient Detoxification</b>   | 80% up to out-of-pocket; 100% thereafter<br>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<br>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<br>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>Prescription Drug Deductible</b><br>Individual<br>Family (limit 2 people/family)                     | \$50<br>\$100  |   |
| <b>Premier Prescription Drug Program</b>  | <p><b>Defined by Premier Gold Pharmacy Network - Not Physician Network.</b><br/><b>(Prescriptions filled at a non-network pharmacy are not covered.)</b></p> <p><b>Retail Drugs</b><br/>Plan pays 75%<br/>Member pays 25%<br/><b>\$100 maximum per RX</b><br/><b>Mandatory Generic<sup>(5)</sup></b><br/><b>31-day Supply</b></p> <p><b>Maintenance Drugs through Mail Order</b><br/>Plan pays 75%<br/>Member pays 25%<br/><b>Mandatory Generic<sup>(5)</sup></b><br/><b>90-day Supply</b><br/><b>\$100 maximum per RX</b></p> |   |

- (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) Prescriptions are covered as long as they are listed on the prescription drug formulary applicable to your plan. 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.

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