

**State System of Higher Education**  
**PPOBlue Benefit Summary\*\***  
*Effective July 1, 2004*

A PPO, or Preferred Provider Organization, offers two levels of benefits. 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 need to select a Primary Care Physician (PCP). No referrals are needed for specialty care. Below are specific benefit levels.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Deductible</b> <i>Per Calendar Year</i>	None	\$250 Individual \$500 Family Aggregate
<b>Payment Level</b> <i>Based on Provider's Reasonable Charge (PRC)</i>	100% PRC	80% PRC after deductible until out-of-pocket limit is met; then 100% PRC
<b>Out-of-Pocket Limit</b> <i>Includes Coinsurance</i>	Not Applicable	\$1,500 Individual \$3,000 Family Aggregate
<b>Lifetime Maximum</b>	Unlimited	\$1,000,000/person
<b>Ambulance</b>	100% PRC	80% PRC after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	Not Covered
<b>Dental Services Related to an Accidental Injury</b>	100% PRC	80% PRC after deductible
<b>Diabetes Treatment</b>	100% PRC	80% PRC after deductible
<b>Diagnostic Services</b> ( <i>Lab, X-ray, and Medical Tests</i> )	100% PRC	80% PRC after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100% PRC	80% PRC after deductible
<b>Elective Abortion</b>	Not Covered (except in cases of rape, incest, or to avert death of the mother)	Not Covered (except in cases of rape, incest, or to avert death of the mother)
<b>Emergency Care</b> <i>Professional Services</i>	100% PRC	100% PRC no deductible
<b>Emergency Room Services</b> <i>Facility Services</i>	100% PRC after \$50 copayment – waived if admitted	
<b>Enteral Formulae</b>	100% PRC	80% PRC no deductible
<b>Hearing Care Services</b>	100% PRC	80% PRC after deductible
<b>Home Health Care</b> <i>Excludes Respite Care</i>	100% PRC	80% PRC after deductible ----- 60 visits/calendar year
<b>Hospice</b> <i>Includes Respite Care</i>	100% PRC	80% PRC after deductible ----- 180 days/benefit period
<b>Hospital Expenses</b> <i>Inpatient and Outpatient</i>	100% PRC	80% PRC after deductible ----- 365 days 2 pint blood deductible/calendar year
<b>Infertility Counseling, Testing and Treatment</b>	100% PRC	80% PRC after deductible
<b>Maternity</b> <i>Excludes Dependent Daughters – covered for complications ONLY</i>	100% PRC	80% PRC after deductible
<b>Medical Care</b> <i>Includes Inpatient Visits and Consultations</i>	100% PRC	80% PRC after deductible

<b>PPOBLUE STANDARD \$5 OFFICE VISIT COPAYMENT OPTION</b>		
<b>BENEFITS</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Mental Health – Inpatient</b> * see below <i>Includes Partial Hospitalization (2 for 1 trade)</i>	100% PRC 30 days/calendar year (up to 30 for serious mental illness)	80% PRC after deductible
<b>Mental Health – Outpatient</b> * see below	100% PRC after \$15 copayment 60 visits/calendar year	50% PRC after deductible
<b>Office Visits</b> <i>PCP and Specialists</i>	100% PRC after \$15 copayment	80% PRC after deductible
<b>Oral Surgery</b>	100% PRC	80% PRC after deductible
<b>Physical Therapy</b> <i>Outpatient</i>	100% PRC after \$15 copayment	80% PRC after deductible Unlimited
<b>Preventive Care</b> <i>Routine Adult Services include:</i> <i>Physical Exam</i> <i>Gynecological Exam &amp; Pap Test</i>  <i>Mammograms</i>	100% PRC after \$15 copayment 100% PRC after \$15 copayment  100% PRC 100% PRC	80% PRC after deductible 80% PRC no deductible/lifetime maximum 80% PRC after deductible 80% PRC after deductible
<i>Routine Pediatric Services include:</i> <i>Physical Exams</i> <i>Pediatric Immunizations</i>	100% PRC after \$15 copayment 100% PRC  100% PRC	80% PRC after deductible 80% PRC no deductible/lifetime maximum 80% PRC after deductible
<b>Private Duty Nursing</b>	100% PRC 240 hours/calendar year	80% PRC after deductible
<b>Skilled Nursing Facility Care</b>	100% PRC 100 days/calendar year	80% PRC after deductible
<b>Speech &amp; Occupational Therapy</b> <i>Outpatient</i>	100% PRC after \$15 copayment 30 visits/calendar year per type of therapy	80% PRC after deductible
<b>Spinal Manipulations</b>	100% PRC after \$15 copayment 30 visits/calendar year	80% PRC after deductible
<b>Substance Abuse - Detoxification</b>	100% PRC 7 days/admission; 4 admissions/lifetime	80% PRC after deductible
<b>Substance Abuse – Inpatient Rehabilitation</b> <i>Includes Partial Hospitalization (2 for 1 trade)</i>	100% PRC 30 days/calendar year; 90 days/lifetime	80% PRC after deductible
<b>Substance Abuse - Outpatient</b>	100% PRC after \$15 copayment 60 visits/calendar year; 120 visits/lifetime	80% PRC after deductible
<b>Surgical Expenses</b> <i>Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, Excludes Neonatal Circumcision</i>	100% PRC	80% PRC after deductible
<b>Therapy Services</b> <i>Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy</i>	100% PRC	80% PRC after deductible
<b>Transplant Services</b>	100% PRC	80% PRC after deductible
<b>Precertification Requirements for Inpatient Admissions</b> <i>No Penalty for Non-compliance</i>	Performed by Network Provider	Performed by Member
<b>Condition Management</b>	Case Management, Blues on Call, and Disease State Management	

*Customized*

\*State mandated benefits (30 inpatient days and 60 outpatient visits annually) may apply for serious diagnosis. Serious diagnosis includes schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder

\*\* This program applies to all active employees and annuitants under the age of 65 retired after July 1, 2004

**This exhibit provides only general information. More detailed information about benefits and eligibility are contained in the Plan Document. If there is a difference between this summary and the Plan Document, the Plan Document will govern.**

## *Health Benefit Exclusions*

Below is a list of services that are typically excluded from coverage unless they are specifically added to the final contract. As exclusion, no benefits will be provided for services, supplies or charges:

1. Which are not medically necessary and appropriate as determined by the plan;
2. Which are not prescribed by or performed by or upon the direction of a professional provider;
3. Rendered by other than providers;
4. Which are experimental/investigative in nature;
5. Rendered prior to the member's effective date;
6. Incurred after the date of termination of the member's coverage;
7. For any illness or injury suffered after the member's effective date as a result of any act of war;
8. For which a member would have no legal obligation to pay;
9. Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
10. To the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the group is obligated by law to offer the member all the benefits and the member so elects this coverage as primary;
11. For any amounts the member is required to pay under the deductible and/or coinsurance provisions of Medicare or any Medicare complementary program;
12. For any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease, or similar type legislation. This exclusion applies whether or not the member files a claim for said benefits or compensation;
13. To the extent benefits are provided to members of the armed forces and the National Health Service or to patients in Veteran's Administration facilities for service-connected illness or injury, unless the member has a legal obligation to pay;
14. For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act;
15. For prescription drugs and medications, except those which are administered to an inpatient in a facility provider;
16. Which are submitted by a certified registered nurse and another professional provider or other provider for the same services performed on the same date for the same member;
17. Rendered by a provider who is a member of the member's immediate family;
18. Performed by a professional provider or other provider enrolled in an education or training program when such services are related to the education or training program;
19. For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise required by law or provider. Other exceptions to this exclusion are: a) Surgery to correct a

- condition resulting from an accident; b) Surgery to correct congenital birth defects; and c) Surgery to correct functional impairment which results from a covered disease or injury;
20. For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
  21. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier-free" home modifications, whether or not specifically recommended by a professional provider or other provider;
  22. For inpatient admissions which are primarily for diagnostic studies;
  23. For inpatient admissions which are primarily for physical therapy;
  24. For custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care;
  25. Directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates;
  26. For oral surgery procedures, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face, unless specifically provided;
  27. For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;
  28. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
  29. For hearing aid devices, tinnitus maskers, or examinations for the prescription or fitting of hearing aids, unless specifically provided;
  30. For any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery;
  31. For artificial insemination;
  32. Related to treatment provided specifically for the purpose of assisted fertilization; including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law;
  33. For routine neonatal circumcision;
  34. For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, (except for aphakic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);
  35. For correction of myopia or hyperopia by means of corneal microsurgery, such as keratomileusis, keratophakia, and radial keratotomy and all related Services;
  36. For treatment of obesity, except for medical and surgical treatment of morbid obesity when weight is at least twice the ideal weight specified for frame, age, height and sex;
  37. For nutritional counseling and services intended to produce weight loss;

38. For any food including, but not limited to, enteral formulae, infant formulas, supplements, substances, products, enteral solutions or compounds used to provide nourishment through the gastrointestinal tract whether ingested orally or provided by tube, whether utilized as a sole or supplemental source of nutrition and when provided on an outpatient basis. This does not include enteral formulae prescribed solely for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria;
39. For preventive care services, wellness services or programs, except as provided in the final contract or as mandated by law;
40. For well-baby care visits, except as provided in the final contract;
41. For routine or periodic physical examinations, the completion of forms, and the preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not medically necessary and appropriate, except as provided in the final contract or mandated by law;
42. For screening examinations including X-ray examinations made without film, except as provided in the final contract;
43. For immunizations required for foreign travel;
44. For the treatment of sexual dysfunction that is not related to organic disease or injury;
45. For any care related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, and mental retardation, which extends beyond traditional medical management or for inpatient confinement for environmental change;
46. For any care, treatment, or service which has been disallowed under the provisions of the Health Care Management Services program;
47. For otherwise covered services ordered by a court or other tribunal as part of the member's or dependent's sentence;
48. For therapy services for which there is no expectation of restoring or improving a level of function exists, or for maintenance treatment, when no additional functional progress is expected to occur, unless Medically Necessary and Appropriate;
49. For any illness or injury suffered after the member's effective date during the member's commission of a felony;
50. For elective abortions, except those abortions necessary to avert the death of the Mother, or to terminate pregnancies caused by rape or incest;
51. For maternity services for Dependent daughters except for complications of pregnancy; and
52. For any other medical or dental service or treatment except as provided in the final contract or as mandated by law

## 2008 Preventive Benefits Schedule



### Save this 2008 Preventive Schedule And save your Health!

This schedule, based on recommendations from the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention and the American College of Obstetricians and Gynecologists, is a reference tool for planning your family's preventive care with your doctor. Your specific needs may vary according to your personal risk factors. Your doctor is always your best resource for determining if you're at an increased risk for a condition. If you have questions about your coverage, please call the toll-free Member Service number on your identification card.

#### Adult (Ages 19+) Preventive Schedule

General Health Care	
<b>Physical Exam/Health Guidance</b>	Every 1-2 years for adults 19-49 years of age. Every year for adults 50 years of age and older.
<b>Blood Pressure Screening</b>	<i>At each physician visit. Minimum of once every two years. Annually if diastolic &gt; 85 mmHg or systolic 130 mmHg</i>
<b>Pelvic Exam/Breast Exam by Practitioner</b>	Annually
Screenings/Procedures	
<b>Lipid Panel Screening</b>	<i>Routine screening every 5 years beginning at age 20. More frequent testing of those at risk for cardiovascular disease.</i>
<b>Fasting Glucose Screening</b>	For high risk individuals, screenings should start at age 45 at three years intervals. Earlier screening may be indicated based on individual risk factors.
<b>Mammogram</b>	Every 1 to 2 years starting at age 40 or as recommended by doctor.*
<b>Pap Test</b>	Test every 1-3 years based on history.*
<b>Chlamydia Screening</b>	Annually for all sexually active non-pregnant women 24 years and younger, and for older non-pregnant who are at increased high-risk..
<b>Other Sexually Transmitted Disease (STD) Screenings</b>	All sexually active males and females, as recommended by your doctor.
<b>Bone Mineral Density Screening</b>	Once every two years: All women 65 years and older. Or, younger post-menopausal women who have had a fracture or have one or more risk factors for osteoporosis.
<b>Prostate Cancer Screening</b>	Discussion risks/benefits of prostate cancer screening. Testing may include annual Prostate Specific Antigen (PSA) and/or digital rectal exam.
<b>Colorectal Cancer Screening</b>	All: beginning at age 50 annual screening with fecal occult blood test (FOBT), or screening with flexible sigmoidoscopy ** every 5 years with or without annual FOBT, or double contrast barium enema every 5 years or colonoscopy every 10 years. High-risk: Earlier or more frequently as recommended by your doctor.
<b>Abdominal Aortic Aneurysm Screening</b>	One-time screening by ultrasonography for men between age 65 and 75 who have ever smoked.
<b>BRCA Mutation Testing</b>	One-time genetic assessment for breast and ovarian cancer susceptibility as recommended by your doctor.
Immunizations	
<b>Diphtheria, Tetanus (Td)</b>	Booster every 10 years for all adults.
<b>Measles, Mumps and Rubella (MMR)</b>	As recommended by your physician. High risk: 2 doses
<b>Pneumococcal</b>	High risk or at age 65: one dose per lifetime with an additional one-time revaccination as recommended by doctor.
<b>Influenza</b>	Annually beginning at age 50 High-risk: Annually between ages 19-49.
<b>Chicken Pox Vaccine</b>	One series of two doses at least one month apart for adults with no history of chicken pox.
<b>Hepatitis A Series</b>	Based on individual risk or physician recommendation: one two-dose series.
<b>Hepatitis B Series</b>	Based on individual risk or physician recommendation: one three-dose series.
<b>Meningococcal</b>	Based on individual risk or physician recommendation: one dose per lifetime.
<b>Human Papillomavirus (HPV)</b>	For females age 19-26 who have not been vaccinated previously, one three dose series. Dose 2 at 2 months from Dose 1. Dose 3 at 6 months from Dose 1.
<b>Zoster</b>	One dose age 60 years of age and older.

\*Complies with PA state mandated benefits.

\*\*Medicare covers one sigmoidoscopy every four years



## 2008 Preventive Benefits Schedule

### Prevention of Obesity

The obesity epidemic places individuals at risk *for* a number of chronic and debilitating diseases. We are working with physicians, policymakers, The Children's Health Fund and representatives from the private sector to address the childhood obesity crisis and to create solutions to obesity-related problems. As part of our prevention of obesity initiative, the following benefits have been added to our Preventive Schedule.

#### Benefits for Children

Children with a body mass index (BMI) in the 95<sup>th</sup> percentile are eligible for:

- Two additional annual preventive office visits specifically for obesity.
- Two annual nutritional counseling visits specifically for obesity
- One set of recommended laboratory studies:
  - Lipid profile  
A lipid panel measures lipids-fats and fatlike substances used as a source of fuel in your body. The panel measures levels of:
    - Total Cholesterol.
    - Triglycerides.
    - High-density lipoprotein (HDL)
    - Low-density lipoprotein (LDL)
- Hemoglobin A1c  
This is a blood test that measures the amount of sugar (glucose) bound to hemoglobin. Normally, only a small percentage of hemoglobin in the blood (4% to 6%) has glucose bound to it. However, people with diabetes (or other conditions that increase their blood glucose levels) have a higher percentage than normal.
- Aspartate Aminotransferase (AST)
  - AST is used to assess liver function.
- Alanine Aminotransferase (ALT)
  - ALT is used to assess liver function.
- Fasting glucose (FBS)
  - This is a measurement of blood glucose taken after you have not eaten for 12 to 14 hours. It is a common test done to screen for diabetes.

Children with a BMI in the 85<sup>th</sup> percentile are eligible for:

- One additional annual preventive office visit specifically for obesity and blood pressure measurement.

#### Benefits for Adults

Adults with a BMI over 30 are eligible for:

- Two additional annual preventive office visits specifically for obesity and blood pressure measurement.
- Two annual nutritional counseling visits specifically for obesity
- One set of recommended laboratory studies:
  - Lipid profile
  - Hemoglobin A1c
  - AST
  - ALT
  - Fasting glucose

