The University of Scranton Classic Blue

Effective: 1-1-2024

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Hospital	Medical/Surgical	Major Medical
General Provisions			
Benefit Period(1)		Calendar Year	
Deductible (per benefit period) Individual Family	 None None	 None None	$150 $450 4th quarter deductible carryover credit does not apply
Plan Pays – payment based on the plan allowance	100%	100% after deductible	80% after deductible
Out-of-Pocket Limit (Once met, plan pays100% coinsurance for the rest of the benefit period) Individual	None	None	$400
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family		$7,550 Medical; $1,900 RX $15,100 Medical; $3,800 RX	
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits & Virtual Visits	not covered	not covered	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	not covered	not covered	80% after deductible
Specialist Office Visits & Virtual Visits	not covered	not covered	80% after deductible
Virtual Visit Originating Site Fee	not covered	not covered	80% after deductible
Urgent Care Center Visits	not covered	not covered	80% after deductible
Telemedicine Services (3)	not covered	not covered	80% after deductible
Preventive Care (3)			
Routine Adult Physical Exams	100%	100%	not covered
Adult Immunizations	100%	100%	not covered
Routine Gynecological Exams	100%	100%	not covered
Routine Pap Smear	100%	100%	not covered
Mammograms, Annual Routine	100%	100%	not covered
Mammograms, Medically Necessary	100%	100%	not covered
Diagnostic Services and Procedures	100%	100%	not covered
Routine Pediatric Physical Exams	100%	100%	not covered
Pediatric Immunizations	100%	100%	not covered
Diagnostic Services and Procedures	100%	100%	not covered
Emergency Services			
Emergency Accident (4)	100%	100%	not covered
Emergency Medical (4)	100%	100%	not covered
Ambulance	not covered	not covered	80% after deductible
Hospital and Medical / Surgical Expenses (including maternity)			
Hospital Inpatient	100% after $5 copay for day for the first 15 days	100%	not covered
Hospital Outpatient	100%	not covered	not covered
Maternity (non-preventive facility & professional services)	100% after $5 copay for day for the first 15 days	100%	not covered
Maternity for Dependent Daughters	100%	100%	not covered
Medical Care (including inpatient visits and consultations) / Surgical Expenses	not covered	100%	not covered

Benefit	Hospital	Medical/Surgical	Major Medical
Therapy and Rehabilitation Services			
Physical Medicine	100%	not covered	80% after deductible
Respiratory Therapy	100% Covered during the 90 day period following an Inpatient stay.	not covered	not covered
Speech Therapy	not covered	not covered	80% after deductible
Occupational Therapy	not covered	not covered	80% after deductible
Spinal Manipulations	not covered	not covered	80% after deductible
Cardiac Rehabilitation Therapy	100%	not covered	not covered
Infusion Therapy	100%	not covered	not covered
Chemotherapy	100%	100%	not covered
Nutritional Therapy	not covered	not covered	80% after deductible. benefit maximum of 6 visits, per member, per benefit period. not subject to deductible
Radiation Therapy	100%	100%	not covered
Dialysis	100%	100%	not covered
Mental Health / Substance Abuse			
Inpatient Mental Health Services	100% after $5 copay for day for the first 15 days	100%	not covered
Inpatient Substance Abuse Detoxification	100% after $5 copay for day for the first 15 days	100%	not covered
Inpatient Substance Abuse Rehabilitation	100%	100%	not covered
Outpatient Mental Health Services (includes virtual behavioral health visits)	not covered	not covered	100% (deductible does not apply)
Outpatient Substance Abuse Services	100%	100%	not covered
Other Services			
Allergy Extracts	not covered	100%	not covered
Allergy Injections	not covered	100%	not covered
Applied Behavior Analysis for Autism Spectrum Disorder (5)	100%	100%	80% after deductible
Assisted Fertilization Procedures	not covered	not covered	not covered
Dental Services Related to Accidental Injury	100%	100%	80% after deductible
Diagnostic Services Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	100%	not covered
Outpatient Diagnostic Services	100%	100%	not covered
Standard Imaging	100%	100%	not covered
Diagnostic Medical	100%	100%	not covered
Pathology/Laboratory	100%	100%	not covered
Allergy Testing	100%	100%	not covered
Durable Medical Equipment Orthotics and Prosthetics (includes coverage for Ostomy supplies)	not covered	not covered	80% after deductible
Home Health Care	100% benefit maximum of 100 visits, per benefit period aggregate with visiting nurse	not covered	not covered
Hospice	100% benefit maximum of 180 days, per lifetime	not covered	not covered
Infertility	100% Testing to determine Infertility only	100% Testing to determine Infertility only	not covered
Private Duty Nursing	not covered	not covered	80% after deductible benefit maximum of 240 hours, per benefit period
Skilled Nursing Facility Care	100% after $5 copay for day for the first 15 days	100%	not covered
Transplant Services	100%	100%	not covered
Precertification Requirements (6)	Yes	No	No
Prescription Drugs			

Benefit	Hospital	Medical/Surgical	Major Medical
Prescription Drug Deductible Individual Family	none none		
Prescription Drug Program (7) Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	**Retail Drugs (30-day Supply)** $10 Formulary generic copay $10 Non-Formulary generic copay $20 Formulary brand copay $35 Non-Formulary brand copay **Maintenance Drugs through Mail Order (90-day Supply)** $10 Formulary generic copay $10 Non-Formulary generic copay $40 Formulary brand copay $70 Non-Formulary brand copay		

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.
(1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) Services are limited to those listed on the Highmark Preventive Schedule with enhancements (Women's Health Preventive Schedule may apply).
(4) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
(5) Diagnostic assessment to diagnose Autism Spectrum Disorders may be performed by a licensed physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner. Diagnostic assessments performed by a licensed physician, licensed physician assistant or certified registered nurse practitioner will be covered as specified in the Office Visit benefit category. Diagnostic assessments performed by a licensed psychologist will be covered as specified in the Mental Health Care Services-Outpatient benefit category. Applied Behavioral Analysis for the treatment of Autism Spectrum Disorders will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g. speech therapy, diagnostic services). Services for the treatment of Autism Spectrum Disorders do not reduce visit/day limits.
(6) If you receive services from an out-of-area provider or a provider who does not participate with the local Blue Cross and/or Blue Shield plan, you must contact Highmark Utilization Management prior to a planned inpatient admission, or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.
(7) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Your plan requires that you use Accredo specialty pharmacy to obtain select specialty medications.

Discrimination is Against the Law

The claims administrator complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The claims administrator does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the claims administrator has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Please note that your employer – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/ program; including, any exclusion or limitation described in the benefit Booklet.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសា ដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់លោកអ្នក (TTY: 711)។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

โปรดทราบ: หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย โทรไปยังหมายเลขที่อยู่ด้านหลังบัตรประจำตัวประชาชนของคุณ (TTY: 711)

ध्यान दिनुहोस्: यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईंका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुनुहुन्छ। तपाईंको आइडी कार्डको पछाडि भागमा रहेको नम्बर (TTY: 711) मा फोन गर्नुहोस्।

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).