Pennsylvania Public School Employees' Retirement System (PSERS)

Selected SecurityBlue Copays and Limits, effective January 1, 2009

All of your care must be provided by your PCP or another network provider. Although referrals are no longer required, it is a good idea to discuss all your heath care needs with your PCP. Remember: you can use only SecurityBlue network doctors, physicians and facilities.

Questions? Call 1-800-227-8195 (TTY User, call 1-800-862-0709)
Reference Code: 09SB4034(Please have this number ready when you call.)

BENEFITS	WHAT YOU PAY
Annual Out-of-Pocket Maximum:	$3,350
PREVENTIVE CARE	
Annual Physical Exam	You pay $10 when provided by PCP or you pay $20 when provided by network OB/GYN.
Annual Gynecological Exam and PAP Test	You pay $20. No referral is required from your PCP.
Annual Mammogram	Covered in full. Office visit copayment may apply.
Annual Routine Eye Exam	You pay $20
Routine Vision Eyewear (Benefit limited to one pair of eyeglass frames and lenses OR one pair of contact lenses every two years)	100% coverage for standard eyeglass frames, lenses, or contact lenses $100/$100 allowance for specialty frames and contact lenses
Annual Routine Hearing Exam	You pay $20
Hearing Aid	SecurityBlue will pay up to $500 for one or more hearing aids every three years
Immunizations (except for travel)	Covered in full. Office visit copayment may apply.
OUTPATIENT SERVICES	
Primary Care Physician Office Visit	You pay $10 per visit
Specialist Office Visit	You pay $20 per visit
Emergency Room Services	You pay $50 per visit. Waived if admitted to the hospital within 3 days for the same condition.
Authorized Outpatient Surgery and Invasive Procedures	Covered in full.
Diagnostic Lab and X-Ray	Covered in full.
Allergy Testing and Treatment	Covered in full. Office visit copayment may apply.
Authorized Durable Medical Equipment *(Oxygen & Oxygen supplies covered at 100%)*	Covered at 85%. You pay 15%. $500 member out-of-pocket maximum
Diabetic Testing Supplies (*Glucose monitors, test strips and lancets)*	Covered at 85%. You pay 15% up to $500 out-of-pocket maximum
Authorized Home Health Care	Covered in full.
Authorized Home IV and Immunosuppressive Therapies	Covered in full.

Authorized Physical, Speech and Occupational Therapy	You pay $20 per visit
Chiropractic Services (for manual manipulation to correct subluxation of the spine)	You pay $20 per visit
Medicare Part B Drugs	**You pay $2 Copay per drug, per provider, per day for most Medicare Part B drugs.** Part B drugs received from out-of-network providers will not be eligible for coverage. **You pay $25 Copay per drug for up to a 34-day supply** for Drugs you take using durable medical equipment (such as nebulizers), drugs used for home infusion therapy, certain oral anti-cancer drugs and anti-nausea.
Ambulance	Covered in full after a $25 copayment per trip.
INPATIENT SERVICES	
Including: • **Semiprivate Room, Hospital Physician Visits, Surgical Services, Nursing Care, Meals, Medical/Surgical Supplies, Drugs and Medications, Lab Tests and X-Rays**	Covered in Full
LTAC (Long term acute care **Authorized Skilled Nursing Facility Care** You are limited to 100 days per benefit period. You are not required to have a hospital stay before you go to a Skilled Nursing Facility.	Covered in Full Covered in Full
MENTAL HEALTH CARE	
Authorized Inpatient Care at Medicare-Approved Participating Facility	Covered in full. Limited to 190 days per lifetime.
Outpatient Mental Health Care	You pay $20 per visit
Outpatient Chemical Dependency Treatment	You pay $20 per visit

HIGHMARK.
SECURITYBLUE
A Medicare Advantage HMO
from Keystone Health Plan West

Highmark Blue Cross Blue Shield and Keystone Health Plan West
are Independent Licensees of the Blue Cross and Blue Shield Association

PRESCRIPTION DRUG PLAN	
Initial Coverage Period Up to $2,700in total drug costs - (combined plan and member total drug expenses)	**For up to a 34-day retail supply**: $20 generic $20 preferred brand $50 non-preferred brand $50 Specialty Drug **For up to a 90-day mail order supply**: $40 generic $40 preferred brand $ 100 non-preferred brand
Coverage Gap Period From $2,700 total drug costs to $4,350 (total member out-of-pocket drug expenses)	**For up to a 34-day retail supply**: $20 generic $20 preferred brand $50 non-preferred brand $50 Specialty Drug **For up to a 90-day mail order supply**: $40 generic $40 preferred brand $ 100 non-preferred brand
Catastrophic Coverage Period After $4,350 (total member out-of-pocket drug expenses)	Member pays the greater of the following: • 5% member coinsurance • $2.40 generic/multi source • $6.00 all other drugs

- If you or your SecurityBlue physician specifies a brand name drug when a generic drug is available, you pay the difference in the cost between the brand name drug and the generic drug in addition to your copayment.

Questions? Call 1-800-227-8195 (TTY User, call 1-800-862-0709)
Reference Code: 09SB4034(Please have this number ready when you call.)