

# Muhlenberg College

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.

Benefit	Network	Out-of-Network
<b>Benefit Period</b> (1)	Contract Year	
<b>Deductible</b> (per benefit period)		
Individual	\$250	\$500
Family	\$500	\$1,000
<b>Plan Payment Level</b> – Based on the provider's reasonable charge (PRC)	100% after deductible	80% after deductible
<b>Out-of-Pocket Maximums</b> (Once met, plan payment level becomes 100%)		
Individual	None	\$3,000
Family	None	\$6,000
<b>Lifetime Maximum</b> (per person)	Unlimited	
<b>Primary Care Physician Office Visits</b>	100% after \$15 copayment	80% after deductible
<b>Specialist Office Visits</b>	100% after \$15 copayment	80% after deductible
<b>Preventive Care</b>		
<i>Adult</i>		
Routine physical exams	100% after \$15 copayment	80% after deductible
Adult Immunizations	100% after deductible	80% after deductible
Routine gynecological exams, including a Pap Test	100% after \$15 copayment	80% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	80% no deductible
<i>Pediatric</i>		
Routine physical exams	100% after \$15 copayment	80% after deductible
Pediatric immunizations	100% (deductible does not apply)	80% (deductible does not apply)
<b>Emergency Room Services</b>	100% after \$50 copayment (waived if admitted)	
<b>Spinal Manipulations</b>	100% after \$15 copayment	80% after deductible
	Unlimited	
<b>Physical Medicine</b>	100% after \$15 copayment	80% after deductible
	Unlimited	
<b>Speech Therapy</b>	100% after \$15 copayment	80% after deductible
	Limit: 12 visits/benefit period	
<b>Occupational Therapy</b>	100% after \$15 copayment	80% after deductible
	Limit: 12 visits/benefit period	
<b>Allergy Extracts and Injections</b>	100% after deductible	80% after deductible
<b>Ambulance</b>	100% no deductible	100% no deductible
<b>Assisted Fertilization Procedures</b>	100% after deductible	80% after deductible
<b>Dental Services Related to Accidental Injury</b>	100% after deductible	80% after deductible
<b>Diabetes Treatment</b>	100% after deductible	80% after deductible
<b>Diagnostic Services (including routine)</b>		
<i>Advanced Imaging</i> (MRI, CAT Scan, PET scan, etc.)	100% after deductible	80% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	100% after deductible	80% after deductible
<b>Enteral Formulae</b>	100% (deductible does not apply)	80% (deductible does not apply)
<b>Home Infusion Therapy</b>	100% after deductible	80% after deductible
<b>Home Health Care</b>	100% after deductible	80% after deductible
	Limit: 90 visits/benefit period	
<b>Hospice</b>	100% after deductible	80% after deductible
<b>Hospital Services – Inpatient</b>	100% after deductible	80% after deductible
<b>Hospital Services – Outpatient</b>	100% after deductible	80% after deductible
<b>Infertility Counseling, Testing and Treatment</b> (2)	100% after deductible	80% after deductible

