

**Small Business Program**  
**PPOBlue Benefit Summary**  
**PPOBlue 1500 80/60 w/ Rx \$8/50%/30%**



PAYMENT LEVEL	IN-NETWORK DEDUCTIBLE	OFFICE VISITS	EMERGENCY ROOM SERVICES
80%/60%	\$1,500/\$3,000	\$0/\$0 Copay	\$0 Copay

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 care. There is no requirement to select a Primary Care Physician (PCP) to coordinate care. Below are specific benefit levels that apply during your benefit period.

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Benefit Period</b>	Contract Year <i>Twelve consecutive months beginning on the contract date</i>	
<b>Deductible Per Benefit Period</b>	\$1,500 Individual \$3,000 Family Aggregate	\$3,000 Individual \$6,000 Family Aggregate
<b>Payment Level</b> <i>Based on Provider's Reasonable Charge (PRC)</i>	80% PRC after deductible until out-of-pocket limit is met; then 100% PRC	60% PRC after deductible until out-of-pocket limit is met; then 100% PRC
<b>Out-of-Pocket Limit</b> <i>Includes Coinsurance, certain exclusions may apply</i>	\$2,500 Individual \$5,000 Family Aggregate	\$5,000 Individual \$10,000 Family Aggregate
<b>Lifetime Maximum</b>	Unlimited	
<b>Ambulance</b>	80% PRC after deductible	60% PRC after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	Not Covered
<b>Dental Services Related to an Accidental Injury</b>	Not Covered	Not Covered
<b>Diabetes Treatment</b>	80% PRC after deductible	60% PRC after deductible
<b>Diagnostic Services (including routine and pre-admission testing)</b> <i>Advanced Imaging (MRI, CAT scan, PET scan, etc.)</i>	80% PRC after deductible	60% PRC after deductible
<i>Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</i>	80% PRC after deductible	60% PRC after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	80% PRC after deductible	60% PRC after deductible
<b>Emergency Room Services</b>	80% PRC no deductible	
<b>Enteral Formulae</b>	80% PRC no deductible	60% PRC no deductible
<b>Hearing Care Services</b>	Not Covered	Not Covered
<b>Home Health Care</b> <i>Excludes Respite Care</i>	80% PRC after deductible	60% PRC after deductible
<b>Hospice</b> <i>Includes Respite Care</i>	80% PRC after deductible	60% PRC after deductible
<b>Hospital Expenses</b> <i>Inpatient and Outpatient</i>	80% PRC after deductible	60% PRC after deductible
<b>Infertility Counseling, Testing and Treatment</b> <i>Treatment includes coverage for the correction of a physical or medical problem associated with infertility.</i>	80% PRC after deductible	60% PRC after deductible
<b>Maternity Includes Dependent Daughters</b>	80% PRC after deductible	60% PRC after deductible
<b>Medical Care</b> <i>Includes Inpatient Visits and Consultations</i>	80% PRC after deductible	60% PRC after deductible
<b>Mental Health Inpatient</b> ①	80% PRC after deductible	60% PRC after deductible
<b>Mental Health Outpatient</b> ①	80% PRC no deductible	60% PRC after deductible
<b>Office Visits</b> <i>Primary Care Physician</i>	80% PRC no deductible	60% PRC after deductible
<i>Specialty Care Physician</i>	80% PRC no deductible	60% PRC after deductible
<b>Oral Surgery</b>	80% PRC after deductible	60% PRC after deductible
<b>Physical Medicine Outpatient</b>	80% PRC no deductible	60% PRC after deductible

		20 visits/benefit period	
PAYMENT LEVEL	IN-NETWORK DEDUCTIBLE	OFFICE VISITS	EMERGENCY ROOM SERVICES
80%/60%	\$1,500/\$3,000	\$0/\$0 Copay	\$0 Copay

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Preventive Care</b> <i>Adult Preventive Care Schedule includes:</i> Routine Physical Exam Immunizations Colorectal Cancer Screening, routine and medically necessary Routine Diagnostic Screening Mammograms, annual routine and medically necessary Routine Gynecological Exam & Pap Test <hr/> <i>Pediatric Preventive Care Schedule includes:</i> Routine Physical Exams Pediatric Immunizations Routine Diagnostic Screening <hr/> <i>Highmark's preventive care schedule is updated periodically based on changes in clinical practice guidelines.</i>	100% PRC no deductible 100% PRC no deductible 80% PRC after deductible 80% PRC after deductible 100% PRC no deductible 100% PRC no deductible/lifetime maximum	60% PRC after deductible 60% PRC after deductible 60% PRC after deductible 60% PRC after deductible 60% PRC after deductible 60% PRC no deductible/lifetime maximum
<b>Private Duty Nursing</b>	80% PRC after deductible	60% PRC after deductible
<b>Skilled Nursing Facility Care</b>	80% PRC after deductible	60% PRC after deductible
<b>Speech &amp; Occupational Therapy</b> <i>Outpatient</i>	80% PRC no deductible	60% PRC after deductible
<b>Spinal Manipulations</b>	80% PRC no deductible	60% PRC after deductible
<b>Substance Abuse Detoxification</b>	80% PRC after deductible	60% PRC after deductible
<b>Substance Abuse Inpatient Rehabilitation</b>	80% PRC after deductible	60% PRC after deductible
<b>Substance Abuse Outpatient</b>	80% PRC no deductible	60% PRC after deductible
<b>Surgical Expenses</b> <i>Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, Excludes Neonatal Circumcision</i>	80% PRC after deductible	60% PRC after deductible
<b>Therapy and Rehabilitation Services</b> <i>Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy</i>	80% PRC after deductible	60% PRC after deductible
<b>Transplant Services</b>	80% PRC after deductible	60% PRC after deductible
<b>Precertification Requirements for Inpatient Admissions</b> <i>No Penalty for Non-compliance. If Highmark Blue Shield is not contacted prior to a non-emergency out-of-network inpatient admission and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, the member will be responsible for any costs not covered.</i>	Performed by Network Provider	Performed by Member
<b>Condition Management</b>	Case Management, Blues on Call, and Disease State Management	

① State mandated minimum benefits may apply to a diagnosis of serious mental illness. (If the above grid does not show a limit, your mental health benefit days and visits are unlimited.)

<b>PRESCRIPTION DRUG BENEFIT</b>	
<b>Deductible</b> ( <i>per benefit period</i> )	None
<b>Prescription Drug Program</b>	<p style="text-align: center;"><b>Retail Drugs (31-day Supply)</b>            \$8 Generic Copay            You pay 50% for Brand Formulary            You pay 70% for Brand Non-Formulary            Up to a \$250 maximum member payment per brand prescription</p> <p style="text-align: center;"><b>Maintenance Drugs through Mail Order (90-day Supply)</b>            \$16 Generic Copay            You pay 50% for Brand Formulary            You pay 70% for Brand Non-Formulary            Up to a \$500 maximum member payment per brand prescription</p>
<b>Formulary</b>	Incentive
<b>Generic Substitution</b>	Soft -When you purchase a brand drug that has a generic equivalent you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs, unless your physician requests that the brand name drug be dispensed
<b>Out-of-Pocket Maximum</b>	Not Applicable
<b>Claim Submission</b>	Pharmacy Files at Point-of-Sale
<b>Non-Network Pharmacy</b>	Not Covered
<b>PRESCRIPTION DRUG CATEGORIES</b>	
<b>Contraceptives</b> ( <i>oral and injectable</i> )	Covered
<b>Fertility Agents</b>	Covered
<b>Fluoride Products</b>	Covered
<b>Insulin and Diabetic Supplies</b>	Covered
<b>Smoking Deterrents</b> ( <i>prescription</i> )	Covered
<b>Vitamins</b> ( <i>prescription</i> )	Covered
<b>Weight Loss Drugs</b>	Covered
<b>Allergy Serum</b>	Not Covered
<b>Durable Medical Equipment</b>	Not Covered
<b>Prescription Hair Growth Products</b>	Not Covered
<b>CARE MANAGEMENT PROGRAMS</b>	
<b>Exclusive Pharmacy Provider</b>	Applies - selected high cost prescription drugs are covered only when they are dispensed through an exclusive pharmacy provider.
<b>Quantity Level Limits</b> <i>on select prescription drugs</i>	Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines.
<b>Managed Rx Coverage</b> <i>on certain drug therapies</i>	Applies – certain drug therapies may be monitored for appropriate usage and subject to case evaluation if recommended guidelines are exceeded..
<b>Managed Prior Authorizations</b>	Applies on select high cost drugs.