Small Business Program
PPOBlue Benefit Summary
PPOBlue 2000 80/60 w/ Rx 8/50/75

PAYMENT LEVEL	IN-NETWORK DEDUCTIBLE	OFFICE VISITS	EMERGENCY ROOM SERVICES
80%/60%	$2,000/$4,000	$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
Benefit Period	Contract Year *Twelve consecutive months beginning on the contract date*	
Deductible *Per Benefit Period*	$2,000 Individual $4,000 Family Aggregate	$4,000 Individual $8,000 Family Aggregate
Payment Level *Based on Provider's Reasonable Charge (PRC)*	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
Out-of-Pocket Limit *Includes Coinsurance, certain exclusions may apply*	$2,500 Individual $5,000 Family Aggregate	$5,000 Individual $10,000 Family Aggregate
Lifetime Maximum	Unlimited	
Ambulance	80% PRC after deductible	60% PRC after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to an Accidental Injury	Not Covered	Not Covered
Diabetes Treatment	80% PRC after deductible	60% PRC after deductible
Diagnostic Services (including routine and pre-admission testing) *Advanced Imaging (MRI, CAT scan, PET scan, etc.)*	80% PRC after deductible	60% PRC after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% PRC after deductible	60% PRC after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% PRC after deductible	60% PRC after deductible
Emergency Room Services	80% PRC no deductible	
Enteral Formulae	80% PRC no deductible	60% PRC no deductible
Hearing Care Services	Not Covered	Not Covered
Home Health Care *Excludes Respite Care*	80% PRC after deductible 90 visits/benefit period	60% PRC after deductible
Hospice *Includes Respite Care*	80% PRC after deductible	60% PRC after deductible
Hospital Expenses *Inpatient and Outpatient*	80% PRC after deductible	60% PRC after deductible
Infertility Counseling, Testing and Treatment *Treatment includes coverage for the correction of a physical or medical problem associated with infertility.*	80% PRC after deductible	60% PRC after deductible
Maternity *Includes Dependent Daughters*	80% PRC after deductible	60% PRC after deductible
Medical Care *Includes Inpatient Visits and Consultations*	80% PRC after deductible	60% PRC after deductible
Mental Health *Inpatient* ①	80% PRC after deductible	60% PRC after deductible
Mental Health *Outpatient* ①	80% PRC no deductible	60% PRC after deductible
Office Visits *Primary Care Physician* *Specialty Care Physician*	 80% PRC no deductible 80% PRC no deductible	 60% PRC after deductible 60% PRC after deductible
Oral Surgery	80% PRC after deductible	60% PRC after deductible

Physical Medicine *Outpatient*	80% PRC no deductible	60% PRC after deductible
	20 visits/benefit period	

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BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Preventive Care		
Adult Preventive Care Schedule includes:		
Routine Physical Exam	100% PRC no deductible	60% PRC after deductible
Immunizations	100% PRC no deductible	60% PRC after deductible
Colorectal Cancer Screening, routine and medically necessary	80% PRC after deductible	60% PRC after deductible
Routine Diagnostic Screening	80% PRC after deductible	60% PRC after deductible
Mammograms, annual routine and medically necessary	100% PRC no deductible	60% PRC after deductible
Routine Gynecological Exam & Pap Test	100% PRC no deductible/lifetime maximum	60% PRC no deductible/lifetime maximum
Pediatric Preventive Care Schedule includes:		
Routine Physical Exams	100% PRC no deductible	60% PRC after deductible
Pediatric Immunizations	100% PRC no deductible/lifetime maximum	60% PRC no deductible/lifetime maximum
Routine Diagnostic Screening	80% PRC after deductible	60% PRC after deductible
Highmark's preventive care schedule is updated periodically based on changes in clinical practice guidelines.		
Private Duty Nursing	80% PRC after deductible	60% PRC after deductible
	240 hours/benefit period	
Skilled Nursing Facility Care	80% PRC after deductible	60% PRC after deductible
	100 days/benefit period	
Speech & Occupational Therapy *Outpatient*	80% PRC no deductible	60% PRC after deductible
	12 visits/benefit period per type of therapy	
Spinal Manipulations	80% PRC no deductible	60% PRC after deductible
	20 visits/benefit period	
Substance Abuse *Detoxification*	80% PRC after deductible	60% PRC after deductible
Substance Abuse *Inpatient Rehabilitation*	80% PRC after deductible	60% PRC after deductible
Substance Abuse *Outpatient*	80% PRC no deductible	60% PRC after deductible
Surgical Expenses *Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, Excludes Neonatal Circumcision*	80% PRC after deductible	60% PRC after deductible
Therapy and Rehabilitation Services *Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy*	80% PRC after deductible	60% PRC after deductible
Transplant Services	80% PRC after deductible	60% PRC after deductible
Precertification Requirements for Inpatient Admissions *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.*	Performed by Network Provider	Performed by Member
Condition Management	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.)

PRESCRIPTION DRUG BENEFIT	
Deductible *(per benefit period)*	None
Prescription Drug Program	**Retail Drugs (31-/60-/90-day Supply)** $8/$16/$24 Generic Copay $50/$100/$150 Brand Formulary Copay $75/$150/$225 Brand Non-Formulary Copay **Maintenance Drugs through Mail Order (90-day Supply)** $20 Generic Copay $125 Brand Formulary Copay $190 Brand Non-Formulary Copay
Formulary	Incentive
Generic Substitution	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
Out-of-Pocket Maximum	Not Applicable
Claim Submission	Pharmacy Files at Point-of-Sale
Non-Network Pharmacy	Not Covered
PRESCRIPTION DRUG CATEGORIES	
Contraceptives *(oral and injectable)*	Covered
Fertility Agents	Covered
Fluoride Products	Covered
Insulin and Diabetic Supplies	Covered
Smoking Deterrents *(prescription)*	Covered
Vitamins *(prescription)*	Covered
Weight Loss Drugs	Covered
Allergy Serum	Not Covered
Durable Medical Equipment	Not Covered
Prescription Hair Growth Products	Not Covered
CARE MANAGEMENT PROGRAMS	
Exclusive Pharmacy Provider	Applies - selected high cost prescription drugs are covered only when they are dispensed through an exclusive pharmacy provider.
Quantity Level Limits *on select prescription drugs*	Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines.
Managed Rx Coverage *on certain drug therapies*	Applies – certain drug therapies may be monitored for appropriate usage and subject to case evaluation if recommended guidelines are exceeded..
Managed Prior Authorizations	Applies on select high cost drugs.