

Small Business Program

PPOBlue Qualified High Deductible Health Plan Benefit Summary

PPOBlue 2600 Qualified HDHP w/ Copays

PAYMENT LEVEL	COMBINED DEDUCTIBLE	OFFICE VISITS	EMERGENCY ROOM SERVICES
100%/80%	\$2,600/\$5,200	\$20/\$35 COPAY	\$100 COPAY

This program is a qualified high deductible health plan as defined by the Internal Revenue Service. It is intended for use with a health Savings Account (HSA), and should not be combined with any funding arrangement other than an HSA.

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. **If you've enrolled as an individual, the deductible and out-of-pocket maximums for the "Employee Only Plan" apply. If you've enrolled as a family, the deductible and out-of-pocket maximums for the "Family Plan" apply, and can be satisfied by one or more of your family members.**

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Benefit Period	Contract Year <i>Twelve consecutive months beginning on the contract date</i>	
Deductible Per Benefit Period <i>Employee Only Plan</i> <i>Family Plan</i>	\$2,600 \$5,200	
Payment Level <i>Based on Provider's Reasonable Charge (PRC)</i>	100% PRC after deductible	80% PRC after deductible until out-of-pocket limit is met; then 100% PRC
Out-of-Pocket Limit <i>Includes all copays and coinsurance. Once met, the plan payment level becomes 100%, and copays do not apply.</i> <i>Employee Only Plan</i> <i>Family Plan</i>	\$2,400 \$4,800	\$4,800 \$9,600
Lifetime Maximum	Unlimited	
Ambulance	100% PRC after deductible	80% PRC after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to an Accidental Injury	Not Covered	
Diabetes Treatment	100% PRC after deductible	80% PRC after deductible
Diagnostic Services (including routine and pre-admission testing) <i>Advanced Imaging (MRI, CAT scan, PET scan, etc.)</i>	100% PRC after deductible	80% PRC after deductible
<i>Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</i>	100% PRC after deductible	80% PRC after deductible
Durable Medical Equipment, Orthotics, Prosthetics	100% PRC after deductible	80% PRC after deductible
Emergency Room Services	\$100 Copay after deductible (waived if admitted)	
Enteral Formulae	100% PRC after deductible	80% PRC after deductible
Hearing Care Services	Not Covered	
Home Health Care <i>Excludes Respite Care</i>	100% PRC after deductible	80% PRC after deductible
Hospice <i>Includes Respite Care</i>	100% PRC after deductible	80% PRC after deductible
Hospital Expenses <i>Inpatient and Outpatient</i>	100% PRC after deductible	80% PRC after deductible
Infertility Counseling, Testing and Treatment <i>Treatment includes coverage for the correction of a physical or medical problem associated with infertility.</i>	100% PRC after deductible	80% PRC after deductible
Maternity <i>Includes Dependent Daughters</i>	100% PRC after deductible	80% PRC after deductible
Medical Care <i>Includes Inpatient Visits and Consultations</i>	100% PRC after deductible	80% PRC after deductible
Mental Health Inpatient ①	100% PRC after deductible	80% PRC after deductible
Mental Health Outpatient ①	100% PRC after deductible	80% PRC after deductible

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BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Office Visits <i>Primary Care Physician</i> <i>Specialty Care Physician</i>	\$20 Copay after deductible \$35 Copay after deductible	80% PRC after deductible 80% PRC after deductible
Oral Surgery	100% PRC after deductible	80% PRC after deductible
Physical Medicine <i>Outpatient</i>	\$35 Copay after deductible	80% PRC after deductible
20 visits/benefit period		
Preventive Care <i>Adult Preventive Care Schedule includes:</i> <i>Routine Physical Exam</i> <i>Immunizations</i> <i>Colorectal Cancer Screening, routine and medically necessary</i> <i>Routine Diagnostic Screening</i> <i>Mammograms</i> <i>Annual routine</i> <i>Medically necessary</i> <i>Routine Gynecological Exam & Pap Test</i>	100% PRC no deductible 100% PRC after deductible 100% PRC after deductible 100% PRC after deductible 100% PRC no deductible 100% PRC after deductible 100% PRC no deductible/lifetime maximum	80% PRC after deductible 80% PRC after deductible 80% PRC after deductible 80% PRC after deductible 80% PRC after deductible 80% PRC after deductible 80% PRC no deductible/lifetime maximum
<i>Pediatric Preventive Care Schedule includes:</i> <i>Routine Physical Exams</i> <i>Pediatric Immunizations</i> <i>Routine Diagnostic Screening</i>	100% PRC no deductible 100% PRC no deductible/lifetime maximum 100% PRC after deductible	80% PRC after deductible 80% PRC no deductible/lifetime maximum 80% PRC after deductible
<i>Highmark's preventive care schedule is updated periodically based on changes in clinical practice guidelines.</i>		
Private Duty Nursing	100% PRC after deductible	80% PRC after deductible
240 hours/benefit period		
Skilled Nursing Facility Care	100% PRC after deductible	80% PRC after deductible
100 days/benefit period		
Speech & Occupational Therapy <i>Outpatient</i>	\$35 Copay after deductible	80% PRC after deductible
12 visits/benefit period per type of therapy		
Spinal Manipulations	\$35 Copay after deductible	80% PRC after deductible
20 visits/benefit period		
Substance Abuse <i>Detoxification</i>	100% PRC after deductible	80% PRC after deductible
Substance Abuse <i>Inpatient Rehabilitation</i>	100% PRC after deductible	80% PRC after deductible
Substance Abuse <i>Outpatient</i>	100% PRC after deductible	80% PRC after deductible
Surgical Expenses <i>Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, Excludes Neonatal Circumcision</i>	100% PRC after deductible	80% PRC after deductible
Therapy and Rehabilitation Services <i>Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy</i>	100% PRC after deductible	80% PRC after deductible
Transplant Services	100% PRC after deductible	80% PRC after deductible
Precertification Requirements for Inpatient Admissions <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
Condition Management	Case Management, Blues on Call, and Disease State Management	

BENEFITS	RETAIL AND MAIL ORDER
Prescription Drug ^② <i>Defined by Premier Pharmacy Network, not the Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>	<p style="text-align: center;">Retail Drugs (31-/60-/90-day Supply) \$8/\$16/\$24 Generic Copay after deductible \$35/\$70/\$105 Brand Formulary Copay after deductible \$50/\$100/\$150 Brand Non-Formulary Copay after deductible</p> <p style="text-align: center;">Maintenance Drugs through Mail Order (90-day Supply) \$20 Generic Copay after deductible \$90 Brand Formulary Copay after deductible \$125 Brand Non-Formulary Copay after deductible</p>

Certain benefits may be subject to day, visit, and/or hour limits. In connection with such benefits, all services received by a Member during a Benefit Period will reduce the remaining number of days, visits, and/or hours available under that benefit, regardless of whether the Member has satisfied his or her Deductible.

- 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.)
- ② At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member coinsurance/copays required based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled.