

**PCI Insurance, Inc. ChamberAdvantage Plan for Sole Proprietors  
PPOBlue HDHP Benefit Summary**

PAYMENT LEVEL	COMBINED DEDUCTIBLE	OFFICE VISITS	EMERGENCY ROOM SERVICES
<b>90%/70%</b>	<b>\$2,600/\$5,200</b>	<b>\$0/\$0 COPAY</b>	<b>\$0 COPAY</b>

**This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). This program 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 enroll as an individual, the deductible and out-of-pocket maximums for the "Employee Only Plan" apply. If you enroll 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
<b>Benefit Period</b>	Contract Year <i>Twelve consecutive months beginning on the contract date</i>	
<b>Deductible</b> <i>Per Benefit Period</i> <i>Employee Only Plan</i> <i>Family Plan</i>	\$2,600 Individual \$5,200 Family	
<b>Payment Level</b> <i>Based on Provider's Reasonable Charge (PRC)</i>	90% PRC after deductible until out-of-pocket limit is met; then 100% PRC	70% PRC after deductible until out-of-pocket limit is met; then 100% PRC
<b>Out-of-Pocket Limit</b> <i>Includes Coinsurance, Copayments and Prescription Drug Expenses, certain exclusions may apply</i> <i>Employee Only Plan</i> <i>Family Plan</i>	\$1,000 Individual \$2,000 Family	\$2,000 Individual \$4,000 Family
<b>Lifetime Maximum</b>	\$5,000,000/Individual	
<b>Ambulance</b>	90% PRC after deductible	70% 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>	90% PRC after deductible	70% PRC after deductible
<b>Diagnostic Services</b> <i>Lab, X-ray, and Medical Tests</i>	90% PRC after deductible	70% PRC after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	90% PRC after deductible	70% PRC after deductible
<b>Emergency Room Services</b>	90% PRC after deductible	
<b>Enteral Formulae</b>	90% PRC after deductible	70% PRC after deductible
<b>Hearing Care Services</b>	Not Covered	Not Covered
<b>Home Health Care</b> <i>Excludes Respite Care</i>	90% PRC after deductible	70% PRC after deductible
<b>Hospice</b> <i>Includes Respite Care</i>	90% PRC after deductible	70% PRC after deductible
<b>Hospital Expenses</b> <i>Inpatient and Outpatient</i>	90% PRC after deductible	70% 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>	90% PRC after deductible	70% PRC after deductible
<b>Maternity</b> <i>Includes Dependent Daughters</i>	90% PRC after deductible	70% PRC after deductible
<b>Medical Care</b> <i>Includes Inpatient Visits and Consultations</i>	90% PRC after deductible	70% PRC after deductible

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BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Mental Health</b> <i>Inpatient</i> ①	90% PRC after deductible	70% PRC after deductible
<b>Mental Health</b> <i>Outpatient</i> ①	90% PRC after deductible	70% PRC after deductible
<b>Office Visits</b> <i>Primary Care Physician</i> <i>Specialty Care Physician</i>	90% PRC after deductible 90% PRC after deductible	70% PRC after deductible 70% PRC after deductible
<b>Oral Surgery</b>	90% PRC after deductible	70% PRC after deductible
<b>Physical Medicine</b> <i>Outpatient</i>	90% PRC after deductible	70% PRC after deductible
----- 20 visits/benefit period		
<b>Preventive Care</b> <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>Screening, Mammography</i> <i>Routine Gynecological Exam &amp; Pap Test</i>	90% PRC no deductible 90% PRC after deductible 90% PRC after deductible  90% PRC after deductible 90% PRC no deductible 90% PRC no deductible/lifetime maximum	70% PRC after deductible 70% PRC after deductible 70% PRC after deductible  70% PRC after deductible 70% PRC after deductible 70% 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>	90% PRC no deductible 90% PRC no deductible/lifetime maximum 90% PRC after deductible	70% PRC after deductible 70% PRC no deductible/lifetime maximum 70% PRC after deductible
----- <i>Highmark's preventive care schedule is updated periodically based on changes in clinical practice guidelines.</i>		
<b>Private Duty Nursing</b>	90% PRC after deductible	70% PRC after deductible
----- 240 hours/benefit period		
<b>Skilled Nursing Facility Care</b>	90% PRC after deductible	70% PRC after deductible
----- 100 days/benefit period		
<b>Speech &amp; Occupational Therapy</b> <i>Outpatient</i>	90% PRC after deductible	70% PRC after deductible
----- 12 visits/benefit period per type of therapy		
<b>Spinal Manipulations</b>	90% PRC after deductible	70% PRC after deductible
----- 20 visits/benefit period		
<b>Substance Abuse</b> <i>Detoxification</i>	90% PRC after deductible	70% PRC after deductible
<b>Substance Abuse</b> <i>Inpatient Rehabilitation</i>	90% PRC after deductible	70% PRC after deductible
<b>Substance Abuse</b> <i>Outpatient</i>	90% PRC after deductible	70% PRC after deductible
<b>Surgical Expenses</b> <i>Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, Excludes Neonatal Circumcision</i>	90% PRC after deductible	70% PRC after deductible
<b>Therapy and Rehabilitation Services</b> <i>Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy</i>	90% PRC after deductible	70% PRC after deductible
<b>Transplant Services</b>	90% PRC after deductible	70% PRC after deductible

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<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	
<b>Prescription Drug</b> <i>Defined by Premier Network, not the Physician Network ②</i>	90% PRC after deductible Retail 31 day supply Mail Order 90 day supply	Not Covered

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 required based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled.