

## 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
<b>Benefit Period</b>	Contract Year <i>Twelve consecutive months beginning on the contract date</i>	
<b>Deductible Per Benefit Period</b> <i>Employee Only Plan</i> <i>Family Plan</i>	\$2,600 \$5,200	
<b>Payment Level</b> <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
<b>Out-of-Pocket Limit</b> <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
<b>Lifetime Maximum</b>	\$5,000,000/Individual	
<b>Ambulance</b>	100% PRC after deductible	80% 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>	100% PRC after deductible	80% PRC after deductible
<b>Diagnostic Services (including routine and pre-admission testing)</b> <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
<b>Durable Medical Equipment, Orthotics, Prosthetics</b>	100% PRC after deductible	80% PRC after deductible
<b>Emergency Room Services</b>	\$100 Copay after deductible (waived if admitted)	
<b>Enteral Formulae</b>	100% PRC after deductible	80% PRC after deductible
<b>Hearing Care Services</b>	Not Covered	Not Covered
<b>Home Health Care</b> <i>Excludes Respite Care</i>	100% PRC after deductible	80% PRC after deductible
<b>Hospice</b> <i>Includes Respite Care</i>	100% PRC after deductible	80% PRC after deductible
<b>Hospital Expenses</b> <i>Inpatient and Outpatient</i>	100% PRC after deductible	80% 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>	100% PRC after deductible	80% PRC after deductible
<b>Maternity</b> <i>Includes Dependent Daughters</i>	100% PRC after deductible	80% PRC after deductible
<b>Medical Care</b> <i>Includes Inpatient Visits and Consultations</i>	100% PRC after deductible	80% PRC after deductible
<b>Mental Health Inpatient</b> ①	100% PRC after deductible	80% PRC after deductible
<b>Mental Health Outpatient</b> ①	\$35 Copay after deductible	80% PRC after deductible

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BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Office Visits</b> <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
<b>Oral Surgery</b>	100% PRC after deductible	80% PRC after deductible
<b>Physical Medicine Outpatient</b>	\$35 Copay after deductible	80% 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>	100% PRC no deductible 100% PRC after deductible 100% PRC after deductible  100% PRC after deductible 100% PRC no 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 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>		
<b>Private Duty Nursing</b>	100% PRC after deductible	80% PRC after deductible
240 hours/benefit period		
<b>Skilled Nursing Facility Care</b>	100% PRC after deductible	80% PRC after deductible
100 days/benefit period		
<b>Speech &amp; Occupational Therapy Outpatient</b>	\$35 Copay after deductible	80% PRC after deductible
12 visits/benefit period per type of therapy		
<b>Spinal Manipulations</b>	\$35 Copay after deductible	80% PRC after deductible
20 visits/benefit period		
<b>Substance Abuse Detoxification</b>	100% PRC after deductible	80% PRC after deductible
<b>Substance Abuse Inpatient Rehabilitation</b>	100% PRC after deductible	80% PRC after deductible
<b>Substance Abuse Outpatient</b>	\$35 Copay after deductible	80% PRC after deductible
<b>Surgical Expenses</b> <i>Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, Excludes Neonatal Circumcision</i>	100% PRC after deductible	80% PRC after deductible
<b>Therapy and Rehabilitation Services</b> <i>Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy</i>	100% PRC after deductible	80% PRC after deductible
<b>Transplant Services</b>	100% PRC after deductible	80% 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	

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<b>Prescription Drug</b> ② <i>Defined by Premier Pharmacy Network, not the Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>	<p align="center"> <b><u>Retail Drugs (31-Day Supply)</u></b>            \$8 Generic Copay after deductible            \$35 Brand Formulary Copay after deductible            \$50 Brand Non-Formulary Copay after deductible   <b><u>Mail-Service Drugs (90-Day Supply)</u></b>            \$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 benefits (30 inpatient days and 60 outpatient visits annually) **may** apply for serious diagnosis. Serious diagnosis includes schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, panic disorder, anorexia nervosa, bulimia nervosa and delusional disorder.
- 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.