

Small Business Program
PPOBlue Benefit Summary
PPOBlue Basic 90/70 w/Incentive Rx



PAYMENT LEVEL	IN-NETWORK DEDUCTIBLE	OFFICE VISITS	EMERGENCY ROOM SERVICES
90%/70%	\$250/\$500	\$20/\$20 COPAY	\$75 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 <i>Twelve consecutive months beginning on the contract date</i>	
Deductible Per Benefit Period	\$250 Individual \$500 Family Aggregate	\$500 Individual \$1,000 Family Aggregate
Payment Level <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
Out-of-Pocket Limit <i>Includes Coinsurance, certain exclusions may apply</i>	\$1,000 Individual \$2,000 Family Aggregate	\$2,500 Individual \$5,000 Family Aggregate
Lifetime Maximum	\$5,000,000/Individual	
Ambulance	90% PRC after deductible	70% PRC after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to an Accidental Injury	Not Covered	Not Covered
Diabetes Treatment	90% PRC after deductible	70% PRC after deductible
Diagnostic Services (including routine and pre-admission testing) <i>Advanced Imaging (MRI, CAT scan, PET scan, etc.)</i>	90% PRC after deductible	70% PRC after deductible
<i>Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)</i>	90% PRC after deductible	70% PRC after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% PRC after deductible	70% PRC after deductible
Emergency Room Services	100% PRC after \$75 Copay – waived if admitted	
Enteral Formulae	90% PRC no deductible	70% PRC no deductible
Hearing Care Services	Not Covered	Not Covered
Home Health Care <i>Excludes Respite Care</i>	90% PRC after deductible	70% PRC after deductible
Hospice <i>Includes Respite Care</i>	90 visits/benefit period	
Hospital Expenses <i>Inpatient and Outpatient</i>	90% PRC after deductible	70% 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>	90% PRC after deductible	70% PRC after deductible
Maternity Includes Dependent Daughters	90% PRC after deductible	70% PRC after deductible
Medical Care <i>Includes Inpatient Visits and Consultations</i>	90% PRC after deductible	70% PRC after deductible
Mental Health Inpatient ①	90% PRC after deductible	70% PRC after deductible
Mental Health Outpatient ①	100% PRC after \$20 Copay	70% PRC after deductible
Office Visits <i>Primary Care Physician</i> <i>Specialty Care Physician</i>	100% PRC after \$20 Copay 100% PRC after \$20 Copay	70% PRC after deductible 70% PRC after deductible
Oral Surgery	90% PRC after deductible	70% PRC after deductible
Physical Medicine Outpatient	100% PRC after \$20 Copay	70% PRC after deductible
	20 visits/benefit period	

PAYMENT LEVEL	IN-NETWORK DEDUCTIBLE	OFFICE VISITS	EMERGENCY ROOM SERVICES
90%/70%	\$250/\$500	\$20/\$20 COPAY	\$75 COPAY

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Preventive Care <i>Adult Preventive Care Schedule includes:</i> Routine Physical Exam Immunizations Colorectal Cancer Screening, routine and medically necessary Routine Diagnostic Screening Screening, Mammography 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 after \$20 Copay 90% PRC after deductible 90% PRC after deductible 90% PRC after deductible 90% PRC no deductible 100% PRC after \$20 Copay/no lifetime maximum 100% PRC after \$20 Copay 90% PRC no deductible/lifetime maximum 90% PRC after deductible	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 70% PRC after deductible 70% PRC no deductible/lifetime maximum 70% PRC after deductible
Private Duty Nursing	90% PRC after deductible	70% PRC after deductible
Skilled Nursing Facility Care	90% PRC after deductible	70% PRC after deductible
Speech & Occupational Therapy <i>Outpatient</i>	100% PRC after \$20 Copay	70% PRC after deductible
Spinal Manipulations	100% PRC after \$20 Copay	70% PRC after deductible
Substance Abuse Detoxification	90% PRC after deductible	70% PRC after deductible
Substance Abuse Inpatient Rehabilitation	90% PRC after deductible	70% PRC after deductible
Substance Abuse Outpatient	100% PRC after \$20 Copay	70% PRC after deductible
Surgical Expenses <i>Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, Excludes Neonatal Circumcision</i>	90% PRC after deductible	70% PRC after deductible
Therapy and Rehabilitation Services <i>Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy</i>	90% PRC after deductible	70% PRC after deductible
Transplant Services	90% PRC after deductible	70% 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	

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.

PRESCRIPTION DRUG	RETAIL PHARMACY	MAIL SERVICE PHARMACY
Deductible (<i>per benefit period</i>)	None	
Prescription Drug - Prescription Drug Card <i>Retail 31 day supply; Mail Order 90 day supply</i>	Three (3) different copay schedules are available (generic/brand names)	
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 (<i>oral and injectable</i>)	Covered	
Fertility Agents	Covered	
Fluoride Products	Covered	
Insulin and Diabetic Supplies	Covered	
Smoking Deterrents (<i>prescription</i>)	Covered	
Vitamins (<i>prescription</i>)	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 <i>on select prescription drugs</i>	Applies – the quantity dispensed under your plan per new or refill prescription may be limited per recommended guidelines.	
Managed Rx Coverage <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..	
Managed Prior Authorizations	Applies on select high cost drugs.	