

PCI Insurance, Inc. - ChamberAdvantage Plan for Small Businesses
PPO Opt 5 - HDHP
PPOBlue HDHP Benefit Summary

PAYMENT LEVEL	COMBINED DEDUCTIBLE	OFFICE VISITS	EMERGENCY ROOM SERVICES
80%/60%	\$1,500/\$3,000	\$0/\$0 COPAY	\$0 COPAY

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
Benefit Period	Contract Year <i>Twelve consecutive months beginning on the contract date</i>	
Deductible <i>Per Benefit Period</i> <i>Employee Only Plan</i> <i>Family Plan</i>	\$1,500 Individual \$3,000 Family	
Payment Level <i>Based on Provider's Reasonable Charge (PRC)</i>	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 <i>Includes Coinsurance, Copayments and Prescription Drug Expenses, certain exclusions may apply</i> <i>Employee Only Plan</i> <i>Family Plan</i>	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 Family
Lifetime Maximum	\$5,000,000/Individual	
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 <i>Lab, X-ray, and Medical Tests</i>	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 after deductible	
Enteral Formulae	80% PRC after deductible	60% PRC after deductible
Hearing Care Services	Not Covered	Not Covered
Home Health Care <i>Excludes Respite Care</i>	80% PRC after deductible	60% PRC after deductible
Hospice <i>Includes Respite Care</i>	80% PRC after deductible	60% PRC after deductible
Hospital Expenses <i>Inpatient and Outpatient</i>	80% PRC after deductible	60% 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>	80% PRC after deductible	60% PRC after deductible
Maternity <i>Includes Dependent Daughters</i>	80% PRC after deductible	60% PRC after deductible
Medical Care <i>Includes Inpatient Visits and Consultations</i>	80% PRC after deductible	60% PRC after deductible

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Mental Health <i>Inpatient ①</i>	80% PRC after deductible	60% PRC after deductible
Mental Health <i>Outpatient ①</i>	80% PRC after deductible	60% PRC after deductible
Office Visits <i>Primary Care Physician</i>	80% PRC after deductible	60% PRC after deductible
<i>Specialty Care Physician</i>	80% PRC after deductible	60% PRC after deductible
Oral Surgery	80% PRC after deductible	60% PRC after deductible
Physical Medicine <i>Outpatient</i>	80% PRC after deductible	60% PRC after deductible
----- 20 visits/benefit period		
Preventive Care <i>Adult Preventive Care Schedule includes:</i>		
<i>Routine Physical Exam</i>	80% PRC no deductible	60% PRC after deductible
<i>Immunizations</i>	80% PRC after deductible	60% PRC after deductible
<i>Colorectal Cancer Screening, routine and medically necessary</i>	80% PRC after deductible	60% PRC after deductible
<i>Routine Diagnostic Screening</i>	80% PRC after deductible	60% PRC after deductible
<i>Screening, Mammography</i>	80% PRC no deductible	60% PRC after deductible
<i>Routine Gynecological Exam & Pap Test</i>	80% PRC no deductible/lifetime maximum	60% PRC no deductible/lifetime maximum

<i>Pediatric Preventive Care Schedule includes:</i>		
<i>Routine Physical Exams</i>	80% PRC no deductible	60% PRC after deductible
<i>Pediatric Immunizations</i>	80% PRC no deductible/lifetime maximum	60% PRC no deductible/lifetime maximum
<i>Routine Diagnostic Screening</i>	80% PRC after deductible	60% PRC after deductible
----- <i>Highmark's preventive care schedule is updated periodically based on changes in clinical practice guidelines.</i>		
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 <i>Outpatient</i>	80% PRC after deductible	60% PRC after deductible
----- 12 visits/benefit period per type of therapy		
Spinal Manipulations	80% PRC after deductible	60% PRC after deductible
----- 20 visits/benefit period		
Substance Abuse <i>Detoxification</i>	80% PRC after deductible	60% PRC after deductible
Substance Abuse <i>Inpatient Rehabilitation</i>	80% PRC after deductible	60% PRC after deductible
Substance Abuse <i>Outpatient</i>	80% PRC after deductible	60% PRC after deductible
Surgical Expenses <i>Includes Assistant Surgery, Anesthesia, Sterilization and Reversal Procedures, Excludes Neonatal Circumcision</i>	80% PRC after deductible	60% PRC after deductible
Therapy and Rehabilitation Services <i>Chemotherapy, Radiation Therapy, Dialysis, Infusion Therapy, Respiratory Therapy</i>	80% PRC after deductible	60% PRC after deductible
Transplant Services	80% PRC after deductible	60% PRC after deductible

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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	
Prescription Drug <i>Defined by Premier Network, not the Physician Network ②</i>	80% 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.