

PCI Insurance, Inc. - ChamberAdvantage Plan for Small Businesses
PPO Opt 2
PPOBlue Benefit Summary

PAYMENT LEVEL	IN-NETWORK DEDUCTIBLE	OFFICE VISITS	EMERGENCY ROOM SERVICES
100%/80%	\$200/\$400	\$20/\$20 COPAY	\$50 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 your care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your 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 <i>Per Benefit Period</i>	\$200 Individual \$400 Family Aggregate	\$400 Individual \$800 Family Aggregate
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 Coinsurance, certain exclusions may apply</i>	Not Applicable	\$3,000 Individual \$6,000 Family Aggregate
Lifetime Maximum	Unlimited	
Ambulance	100% PRC after deductible	80% PRC after deductible
Assisted Fertilization Procedures	Not Covered	Not Covered
Dental Services Related to an Accidental Injury	Not Covered	Not Covered
Diabetes Treatment	100% PRC after deductible	80% PRC after deductible
Diagnostic Services <i>Lab, X-ray, and Medical Tests</i>	100% PRC after deductible	80% PRC after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% PRC after deductible	80% PRC after deductible
Emergency Room Services	100% PRC after \$50 Copay – waived if admitted	
Enteral Formulae	100% PRC no deductible	80% PRC no deductible
Hearing Care Services	Not Covered	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 <i>Inpatient ①</i>	100% PRC after deductible	80% PRC after deductible
Mental Health <i>Outpatient ①</i>	100% PRC after \$20 Copay	80% PRC after deductible
Office Visits <i>Primary Care Physician</i>	100% PRC after \$20 Copay	80% PRC after deductible
<i>Specialty Care Physician</i>	100% PRC after \$20 Copay	80% PRC after deductible

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BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Oral Surgery	100% PRC after deductible	80% PRC after deductible
Physical Medicine <i>Outpatient</i>	100% PRC after \$20 Copay 20 visits/benefit period	80% PRC after deductible
<i>Adult Preventive Care Schedule includes:</i>		
<i>Routine Physical Exam</i>	100% PRC after \$20 Copay	80% PRC after deductible
<i>Immunizations</i>	100% PRC after deductible	80% PRC after deductible
<i>Colorectal Cancer Screening, routine and medically necessary</i>	100% PRC after deductible	80% PRC after deductible
<i>Routine Diagnostic Screening</i>	100% PRC after deductible	80% PRC after deductible
<i>Screening, Mammography</i>	100% PRC no deductible	80% PRC after deductible
<i>Routine Gynecological Exam & Pap Test</i>	100% PRC after \$20 Copay	80% PRC no deductible
<i>Pediatric Preventive Care Schedule includes:</i>		
<i>Routine Physical Exams</i>	100% PRC after \$20 Copay	80% PRC after deductible
<i>Pediatric Immunizations</i>	100% PRC no deductible	80% PRC no deductible
<i>Routine Diagnostic Screening</i>	100% PRC after deductible	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 240 hours/benefit period	80% PRC after deductible
Skilled Nursing Facility Care	100% PRC after deductible 100 days/benefit period	80% PRC after deductible
Speech & Occupational Therapy <i>Outpatient</i>	100% PRC after \$20 Copay 12 visits/benefit period per type of therapy	80% PRC after deductible
Spinal Manipulations	100% PRC after \$20 Copay 20 visits/benefit period	80% PRC after deductible
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 \$20 Copay	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	

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.)