Silver

# Comprehensive Care Blue PPO 1500

**Benefit Period: January 1, 2015 to December 31, 2015**

## Are you comfortable meeting a low deductible before coverage starts?

Comprehensive Care Blue plans offer a low yearly deductible and low out-of-pocket max. You pay for all medical services until your deductible is met. Then you pay copays or a percentage of your care costs until your out-of-pocket max is met.

If you are looking for additional plan details, each plan's Summary of Benefits and Coverage is available online at HighmarkBCBS.com/SBC/BCBS. With this information, you'll be able to shop and compare with confidence. If you do not have online access, you can get a paper copy of any Summary of Benefits free of charge by calling toll-free 1-855-329-3004.

## Questions

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# Comprehensive Care Blue PPO 1500 Explained

| Plan Details | In Network | Out of Network |
|---|---|---|
| | You Pay[1] | You Pay |
| Deductible – Individual | $1,500 | $3,000 |
| Deductible – Family[2] | $3,000 | $6,000 |
| Coinsurance | 20% after deductible | 40% after deductible |
| Out-of-Pocket Limit – Individual | $6,350 | $12,700 |
| Out-of-Pocket Limit – Family | $12,700 | $25,400 |
| Network | Keystone Health Plan West | |
| Preventive Care[3] – Annual deductible and coinsurance do not apply to the Preventive Care services | | |
| Routine Annual Physical Exam<br>Routine Annual Gynecological Exam<br>Immunizations – Adult and Pediatric<br>Routine Mammogram Screenings<br>Preventive Medications[4] | 0% | 100% |
| Illness or Injury Care | | |
| Primary Care Office/Clinic Visit | $35 copay after deductible | 40% after deductible |
| Specialist Office/Urgent Care Visit | $70 copay after deductible | 40% after deductible |
| Emergency Room Visit | 20% after deductible | 20% after in-network deductible |
| Prescription Drugs[5] | HCR Progressive Formulary<br>Generic: $8 Brand: $45 | 100% |
| Maternity Services | 20% after deductible | 40% after deductible |
| Inpatient Hospital Services | 20% after deductible | 40% after deductible |
| Medical/Surgical Expenses | 20% after deductible | 40% after deductible |
| Diagnostic Services[6]<br>(Basic and Advanced Diagnostic Services) | Basic: $40 copay<br>Advanced: 20% after deductible | 40% after deductible |
| Therapy and Rehabilitation Services[7] | 20% after deductible | 40% after deductible |
| Mental Health/Substance Abuse Services | Outpatient: $70 copay after deductible;<br>Inpatient: 20% after deductible | 40% after deductible |
| Routine Eye Exam (Every 24 months) | 0% | 100% |
| Pediatric Dental | Exam/Cleaning: 0%; All other benefits:<br>50% after deductible | 100% |
| Pediatric Vision | Exam: 0%;<br>Frames/Lenses: 0% | 100% |

[1]You are responsible for out-of-pocket costs each Benefit Period up to a maximum amount shown. Thereafter, the Plan pays 100% of the Provider's Allowable Charge during the remainder of the Benefit Period. This amount does not include amounts in excess of the Provider's Allowable Charge.

[2]For an Agreement covering more than one (1) family member, as each Member satisfies their individual Deductible, the Plan will begin to pay benefits for Covered Services for that Member for the remainder of the Benefit Period, whether or not the entire family Deductible has been satisfied. When the family Deductible has been satisfied, the family Deductible will be considered to have been satisfied for all remaining covered family members. No individual Member may satisfy the entire family Deductible.

[3]The Highmark Preventive Service Schedule is reviewed and updated periodically based on the requirements of the Patient Protection and Affordable Care Act of 2010, as amended, and the advice of the American Academy of Pediatrics, U.S. Preventive Service Task Force, the Blue Cross and Blue Shield Association and Medical Consultants. Accordingly, the frequency and eligibility of services is subject to change.

[4]Certain limited prescriptions and over-the-counter drugs prescribed for preventive purposes.

[5]Prescription Drug copays for a 31 day supply (Retail): $8 Generic; $45 Brand; $95 non-formulary Brand/Generic and formulary Specialty; 25% coinsurance on non-formulary Specialty Drug up to $200 maximum (no deductible). The plan has a four-tier structure and utilizes the HCR Progressive Formulary on the Premier 2012 network. Mail order available. If a generic substitution is available but not accepted by the Member, they are responsible for paying the difference between the Brand Drug price and the available Generic equivalent for each separate Prescription Drug Order or refill along with the drug copay.

[6]Basic Diagnostic Services include four types of service: Standard Imaging Services, Laboratory and Pathology, Diagnostic Medical and Allergy Testing. Basic Diagnostic Services require one copayment per date of service and type of service. Additional Basic Diagnostic Services are subject to deductible and coinsurance. Advanced Diagnostic Services include but are not limited to CAT Scan, CTA, MRI, MRA, PET Scan and PET/CT Scan.

[7]Therapy visit limits include in and out-of-network visits. Physical medicine is limited to 30 visits per contract year combined for Rehabilitative and Habilitative services. Speech therapy and occupational therapy are a combined 30 visit limit per contract year combined for Rehabilitative and Habilitative services.