

Gold

Flex Blue PPO 1200 PA Mountains Healthcare Region, *a Community Blue Plan*

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



Do you want to choose a level of providers who give you the most for your health care dollars?

With Flex Blue, you get the most value when you choose providers who deliver quality care more effectively in the Enhanced level. These plans tend to have a low out-of-pocket max.



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.



Counties where Flex Blue PPO 1200 PA Mountains Healthcare Region, a Community Blue Plan is available

- | | | | |
|-------------|------------|-------------|----------|
| » Armstrong | » Clarion | » Indiana | » McKean |
| » Blair | » Crawford | » Jefferson | » Potter |
| » Cameron | » Forest | » Lawrence | |



Questions



HighmarkBCBS.com

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Highmark Blue Cross Blue Shield does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

Highmark Blue Cross Blue Shield is a Qualified Health Plan issuer in the Health Insurance Marketplace.

Flex Blue PPO 1200 PA Mountains Healthcare Region, a Community Blue Plan Explained



Plan Details	In Network	Out of Network
	You Pay ¹	You Pay
Deductible – Individual	\$1,200 Enhanced \$2,400 Standard (Deductibles Cross-Accumulate)*	\$4,800
Deductible – Family ²	\$2,400 Enhanced \$4,800 Standard (Deductibles Cross-Accumulate)*	\$9,600
Coinsurance	Enhanced: 20% Standard: 40% after deductible	60% after deductible
Out-of-Pocket Limit – Individual	\$3,600 Combined**	\$7,200
Out-of-Pocket Limit – Family	\$7,200 Combined**	\$14,400
Network	Community Blue	
Preventive Care ³ – Annual deductible and coinsurance do not apply to the Preventive Care services		
Routine Annual Physical Exam Routine Annual Gynecological Exam Immunizations – Adult and Pediatric Routine Mammogram Screenings Preventive Medications ⁴	0%	100%
Illness or Injury Care		
Primary Care Office/Clinic Visit	Enhanced: \$20 copay Standard: \$50 copay	60% after deductible
Specialist Office/Urgent Care Visit	Enhanced: \$30 copay Standard: \$60 copay	60% after deductible
Emergency Room Visit	Enhanced/Standard: 20% after deductible	20% after deductible
Prescription Drugs ⁵	HCR Progressive Formulary Generic: \$8 Brand: \$45	100%
Maternity Services	Enhanced: 20% Standard: 40% after deductible	60% after deductible
Inpatient Hospital Services	Enhanced: 20% Standard: 40% after deductible	60% after deductible
Medical/Surgical Expenses	Enhanced: 20% Standard: 40% after deductible	60% after deductible
Diagnostic Services ⁶ (Basic and Advanced Diagnostic Services)	Basic: Enhanced: \$20 copay Standard: \$50 copay Advanced: after deductible Enhanced: 20% Standard: 40%	60% after deductible
Therapy and Rehabilitation Services ⁷	Enhanced: 20% Standard: 40% after deductible	60% after deductible
Mental Health/Substance Abuse Services	Outpatient: \$30 copay Inpatient: 20% after deductible	60% after deductible
Routine Eye Exam (Every 24 months)	0%	100%
Pediatric Dental	Exam/Cleaning: 0%; All other benefits: 50% after deductible	100%
Pediatric Vision	Exam: 0%; Frames/Lenses: 0%	100%
Wellness Rewards is available with this plan.***		

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

²For 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.

³The 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.

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

⁵Prescription 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.

⁶Basic 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.

⁷Therapy 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.

***In-Network Cross-accumulate** means that any in-network deductible costs that you incur when receiving covered services at the Enhanced Value or Standard Value levels of benefits count toward **both** your Enhanced Value **and** your Standard Value deductibles.

****Out-of-pocket Maximums are Combined for in-network services**, which means that any costs you incur when receiving covered services at either the Enhanced Value or Standard Value levels of benefits count toward the **same in-network Out-of-pocket Maximum**.

*****Any cash or cash equivalent reward** (for example, a debit card) you receive for satisfying the program requirements may result in taxable income to you. Consult your tax advisor for further information.