Silver

Health Savings Blue PPO 2750

a Community Blue Flex Plan

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

Do you want the tax and savings advantages of a Health Savings Account (HSA)?

Health Savings are our only qualified high-deductible health plans that offer the tax and savings advantages of Health Savings Accounts (HSA). You pay all costs until your deductible is met. Then you pay a percentage of costs until you meet your out-of-pocket max.

This Health Savings Plan is a Qualified High Deductible Health Plan that may be coupled with a Health Savings Account (HSA). However, certain cost-sharing reductions (CSR) or plan variations of this plan that are offered through the Health Insurance Marketplace are not intended to be used with an HSA. If you have questions, please check with your financial advisor.

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 Health Savings Blue PPO 2750 a Community Blue Flex Plan is available

- Allegheny
- Armstrong
- Beaver
- Butler
- Crawford
- Erie
- Fayette
- Greene
- Indiana
- Lawrence
- McKean
- Mercer
- Warren
- Washington
- Westmoreland

Questions

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HighmarkBCBS.com

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Health Savings Blue PPO 2750
a Community Blue Flex Plan Explained

Plan Details	In Network	Out of Network
	You Pay[1]	You Pay
Deductible – Individual	$2,750 Combined*	$5,500
Deductible – Family[2]	$5,500 Combined*	$11,000
Coinsurance	Enhanced: 20% Standard: 40% after deductible	50% after deductible
Out-of-Pocket Limit – Individual	$4,000 Combined**	$8,000
Out-of-Pocket Limit – Family	$8,000 Combined**	$16,000
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	after deductible: Enhanced: 20% Standard: 40%	50% after deductible
Specialist Office/Urgent Care Visit	after deductible: Enhanced: 20% Standard: 40%	50% after deductible
Emergency Room Visit	20% after deductible	20% after in-network deductible
Prescription Drugs[5]	Open HCR Comprehensive Formulary 20% after deductible	100%
Maternity Services	Enhanced: 20% Standard: 40% after deductible	50% after deductible
Inpatient Hospital Services	after deductible: Enhanced: 20% Standard: 40%	50% after deductible
Medical/Surgical Expenses	Enhanced: 20% Standard: 40% after deductible	50% after deductible
Diagnostic Services[6] (Basic and Advanced Diagnostic Services)	Basic & Advanced: after deductible Enhanced: 20% Standard: 40%	50% after deductible
Therapy and Rehabilitation Services[7]	Enhanced: 20% after deductible Standard: 40% after deductible	50% after deductible
Mental Health/Substance Abuse Services	20% after deductible outpatient and inpatient	50% after deductible
Routine Eye Exam (Every 24 months)	0%	100%
Pediatric Dental	Exam/Cleaning: 0%; All other benefits: 20% after deductible	100%
Pediatric Vision	Exam: 0%; Frames/Lenses: 0% after deductible	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, the ENTIRE family deductible must be met (within a benefit period) before Highmark will pay for covered services for ANY family member. The family deductible can be satisfied by an individual family member or a combination of one or more family members.
[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]The plan utilizes the HCR Comprehensive Formulary on the Premier 2012 network. Mail order available.
[6]Basic Diagnostic Services include four types of service: Standard Imaging Services, Laboratory and Pathology, Diagnostic Medical and Allergy Testing. 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.
***In-Network Combined** means that any in-network deductible costs you incur when receiving covered services at either the Enhanced Value or Standard Value levels of benefits count toward the **same in-network deductible.**
****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.**