Gold

Shared Cost Blue PPO 1000

a Community Blue Flex Plan

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

Do you want some copays with coverage right from the start?

Shared Cost plans have copays with coverage for some services right from the start. For other services, you need to meet your deductible before we pay for your care. These plans have a wide range of deductibles.

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 Shared Cost Blue PPO 1000 a Community Blue Flex Plan is available

- Bedford
- Blair
- Cambria
- Cameron
- Centre
- Clarion
- Clearfield
- Elk
- Forest
- Huntingdon
- Jefferson
- Potter
- Somerset
- Venango

Questions

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Shared Cost Blue PPO 1000
a Community Blue Flex Plan Explained

Plan Details	In Network	Out of Network
	You Pay[1]	You Pay
Deductible – Individual	$1,000 Enhanced $2,500 Standard (Deductibles Cross-Accumulate)*	$5,000
Deductible – Family[2]	$2,000 Enhanced $5,000 Standard (Deductibles Cross-Accumulate)*	$10,000
Coinsurance	Enhanced: 20% Standard: 40% after deductible	50% after deductible
Out-of-Pocket Limit – Individual	$4,250 Combined**	$8,500
Out-of-Pocket Limit – Family	$8,500 Combined**	$17,000
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	Enhanced: $25 copay Standard: $50 copay	50% after deductible
Specialist Office/Urgent Care Visit	Enhanced: $50 copay Standard: $80 copay	50% after deductible
Emergency Room Visit	$150 copay	$150 copay
Prescription Drugs[5]	HCR Progressive Formulary Generic: $8 Brand: $45	100%
Maternity Services	20% after deductible	50% after deductible
Inpatient Hospital Services	Enhanced: 20% after $500 copay per admission; Standard: 40% after $750 copay per admission	50% after deductible
Medical/Surgical Expenses	Enhanced: 20% after deductible Standard: 40% after deductible	50% after deductible
Diagnostic Services[6] (Basic and Advanced Diagnostic Services)	Basic: Lab, X-ray: Enhanced: $25 copay Standard: $50 copay Advanced: Enhanced: $150 copay Standard: $250 copay	50% after deductible
Therapy and Rehabilitation Services[7]	Enhanced: 20% after deductible Standard: 40% after deductible	50% after deductible
Mental Health/Substance Abuse Services	Outpatient: $50 copay; Inpatient: 20% after $500 copay per admission	50% 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%

[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.

***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.**