

Silver

Shared Cost Blue PPO 2100

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 2100 a Community Blue Flex Plan is available

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



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.

Shared Cost Blue PPO 2100 a Community Blue Flex Plan Explained



| Plan Details | In Network | Out of Network |
|---|---|---------------------------------|
| | You Pay ¹ | You Pay |
| Deductible – Individual | \$2,100 Enhanced \$4,200 Standard (Deductibles Cross-Accumulate)* | \$8,400 |
| Deductible – Family ² | \$4,200 Enhanced \$8,400 Standard (Deductibles Cross-Accumulate)* | \$16,800 |
| Coinsurance* | Enhanced: 30% Standard: 50% after deductible | 60% after deductible |
| Out-of-Pocket Limit – Individual | \$6,350 Combined** | \$12,700 |
| Out-of-Pocket Limit – Family | \$12,700 Combined** | \$25,400 |
| Network | Community Blue | |
| Preventive Care ³ – Annual deductible and coinsurance <u>do not apply</u> 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 \$45 copay Standard: \$75 copay | 60% after deductible |
| Specialist Office/Urgent Care Visit | Enhanced \$90 copay Standard: \$120 copay | 60% after deductible |
| Emergency Room Visit | 30% after deductible | 30% after in-network deductible |
| Prescription Drugs ⁵ | HCR Progressive Formulary Generic: \$8 Brand: \$45 | 100% |
| Maternity Services* | 30% after deductible | 60% after deductible |
| Inpatient Hospital Services | Enhanced: 30% after \$950 copay per admission; Standard: 50% after \$2,000 copay per admission | 60% after deductible |
| Medical/Surgical Expenses* | 30% after deductible | 60% after deductible |
| Diagnostic Services ⁶ (Basic and Advanced Diagnostic Services) | Basic: Enhanced: \$50 copay Standard: \$75 copay Advanced: Enhanced: \$250 copay Standard: \$500 copay | 60% after deductible |
| Therapy and Rehabilitation Services* ⁷ | 30% after deductible | 60% after deductible |
| Mental Health/Substance Abuse Services | Outpatient: \$90 copay; Inpatient: 30% after \$950 copay per admission | 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% |

¹You 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.

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**.