

Silver

Shared Cost Blue PPO 2650

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 2650 a Community Blue Flex Plan is available

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



Questions



HighmarkBCBS.com

Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks of the Blue Cross and Blue Shield Association. Highmark is a registered mark of Highmark Inc. Information regarding the Patient Protection and Affordable Care Act of 2010 (a.k.a. "PPACA", "Affordable Care Act", "ACA", and/or "Health Care Reform"), as amended, and/or any other law, does not constitute legal or tax advice and is subject to change based upon the issuance of new guidance and/or change in laws. State laws may be applicable. Any review of materials, request for information, or application does not obligate you to enroll for coverage. Please request the Outline of Coverage for details on benefits, conditions and exclusions. Providing your information is voluntary. We are committed to providing outstanding services for our applicants and members. If you require special assistance, including accommodations for disabilities or limited English proficiency, please call us at 1-800-876-7639 to request these free services (TTY/TDD users may call 711).

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 2650 a Community Blue Flex Plan Explained



Plan Details	In Network	Out of Network
	You Pay ¹	You Pay
Deductible – Individual	\$2,650 Enhanced \$5,300 Standard (Deductibles Cross-Accumulate)*	\$5,300
Deductible – Family ²	\$5,300 Enhanced \$10,600 Standard (Deductibles Cross-Accumulate)*	\$10,600
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: \$40 copay Standard: \$60 copay	60% after deductible
Specialist Office/Urgent Care Visit	Enhanced: \$60 copay Standard: \$80 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 deductible Standard: 50% after deductible	60% after deductible
Medical/Surgical Expenses*	30% after deductible	60% after deductible
Diagnostic Services ⁶ (Basic and Advanced Diagnostic Services)	Basic: Enhanced: \$40 copay Standard: \$60 copay Advanced: after deductible Enhanced: 30% Standard: 50%	60% after deductible
Therapy and Rehabilitation Services* ⁷	30% after deductible	60% after deductible
Mental Health/Substance Abuse Services	Outpatient: \$60 copay; Inpatient: 30% 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%

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**.