Bronze

Shared Cost Blue PPO 5500

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.

Questions

HIGHMARK. HEALTH INSURANCE COMPANY

HighmarkBCBS.com

26537 (11/14)

Shared Cost Blue PPO 5500 Explained

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Plan Details	In Network	Out of Network
	You Pay[1]	You Pay
Deductible – Individual	$5,500	$11,000
Deductible – Family[2]	$11,000	$22,000
Coinsurance	40% after deductible	50% after deductible
Out-of-Pocket Limit – Individual	$6,350	$12,700
Out-of-Pocket Limit – Family	$12,700	$25,400
Network	Keystone Health Plan West	
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	$50 copay	50% after deductible
Specialist Office/Urgent Care Visit	$90 copay	50% after deductible
Emergency Room Visit	40% after deductible	40% after in-network deductible
Prescription Drugs[5]	HCR Open Comprehensive Formulary 40% after deductible	100%
Maternity Services	40% after deductible	50% after deductible
Inpatient Hospital Services	40% after deductible	50% after deductible
Medical/Surgical Expenses	40% after deductible	50% after deductible
Diagnostic Services[6] (Basic and Advanced Diagnostic Services)	Basic: $50 copay Advanced: 40% after deductible	50% after deductible
Therapy and Rehabilitation Services[7]	40% after deductible	50% after deductible
Mental Health/Substance Abuse Services	Outpatient: $90 copay; Inpatient: 40% after deductible	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]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. 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.