

**Highmark Blue Cross Blue Shield:  
Shared Cost Blue PPO 5500 a Community Blue Flex Plan**

Coverage Period: 01/01/2015 - 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.highmarkbcbs.com](http://www.highmarkbcbs.com) or by calling 1-888-510-1084.

Important Questions	Answers	Why this Matters:
<p><b>What is the overall <u>deductible</u>?</b></p>	<p><b>\$5,500</b> individual/<b>\$11,000</b> family combined enhanced value network and standard value network, <b>\$11,000</b> individual/<b>\$22,000</b> family out-of-network.</p> <p><b><u>Network deductible</u></b> does not apply to office visits, preventive care services, urgent care, diagnostic testing, outpatient mental health, and outpatient substance use disorder.</p> <p>Copayments, coinsurance amounts don't count toward the <b><u>network deductible</u></b>.</p>	<p>You must pay all the costs up to the <b><u>deductible</u></b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b><u>deductible</u></b> starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the <b><u>deductible</u></b>.</p>
<p><b>Are there other <u>deductibles</u> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <b><u>deductibles</u></b> for specific services, but see the chart starting on page 3 for other costs for services this plan covers.</p>
<p><b>Is there an <u>out-of-pocket limit</u> on my expenses?</b></p>	<p>Network: <b>\$6,350</b> individual/<b>\$12,700</b> family total maximum out-of-pocket.</p> <p>Out-of-network: <b>\$12,700</b> individual/<b>\$25,400</b> family.</p>	<p>The <b><u>out-of-pocket limit</u></b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>

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<p><b>What is not included in the <u>out-of-pocket limit</u>?</b></p>	<p>Enhanced and standard value network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket.</p> <p>Out-of-network: Premiums, balance-billed charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p><b>Is there an overall annual limit on what the plan pays?</b></p>	<p>No.</p>	<p>The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.</p>
<p><b>Does this plan use a <u>network of providers</u>?</b></p>	<p>Yes. For a list of <u>network providers</u>, see <a href="http://www.highmarkbcbs.com">www.highmarkbcbs.com</a> or call 1-888-510-1084.</p>	<p>If you use a <u>network</u> doctor or other health care <u>provider</u>, this plan will pay some or all of the costs of covered services. Be aware, your <u>network</u> doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u>, or participating for <u>providers</u> in their <u>network</u>. See the chart starting on page 3 for how this plan pays different kinds of <u>providers</u>.</p>
<p><b>Do I need a referral to see a <u>specialist</u>?</b></p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without permission from this plan.</p>
<p><b>Are there services this plan doesn't cover?</b></p>	<p>Yes.</p>	<p>Some of the services this plan doesn't cover are listed in the Excluded Services &amp; Other Covered Services section. See your policy or plan document for additional information about <u>excluded services</u>.</p>

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an Enhanced Value (Network) Provider	Your Cost if You Use a Standard Value (Network) Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$50 copay/visit	\$75 copay/visit	70% coinsurance	-----none-----
	Specialist visit	\$90 copay/visit	\$115 copay/visit	70% coinsurance	-----none-----
	Other practitioner office visit	\$90 copay/visit for chiropractor	\$115 copay/visit for chiropractor	70% coinsurance for chiropractor	Combined network and out-of-network: 20 visits per benefit period.
	Preventive care Screening Immunization	No charge for preventive care services	No charge for preventive care services	No coverage for preventive care services	Please refer to your preventive schedule for additional information.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	\$50 copay/visit	\$75 copay/visit	70% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	40% coinsurance	60% coinsurance	70% coinsurance	-----none-----

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<b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at 1-888-510-1084.	Generic drugs	40% coinsurance (retail) 40% coinsurance (mail order)	40% coinsurance (retail) 40% coinsurance (mail order)	Not covered	Up to 31/60/90-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. Certain participating retail pharmacy providers may have agreed to make maintenance prescription drugs available at the same cost-sharing and quantity limits as the mail service coverage.
	Formulary Brand drugs	40% coinsurance (retail) 40% coinsurance (mail order)	40% coinsurance (retail) 40% coinsurance (mail order)	Not covered	
	Non-Formulary Brand drugs	40% coinsurance (retail) 40% coinsurance (mail order)	40% coinsurance (retail) 40% coinsurance (mail order)	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	60% coinsurance	70% coinsurance	-----none-----
	Physician/surgeon fees	40% coinsurance	60% coinsurance	70% coinsurance	-----none-----
<b>If you need immediate medical attention</b>	Emergency room services	40% coinsurance	40% coinsurance	40% coinsurance	All tiers: Subject to enhanced value network deductible.
	Emergency medical transportation	40% coinsurance	40% coinsurance	40% coinsurance	All tiers: Subject to enhanced value network deductible.
	Urgent care	\$90 copay/visit	\$115 copay/visit	70% coinsurance	-----none-----

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<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	40% coinsurance	60% coinsurance	70% coinsurance	Out-of-network: 90 days per benefit period combined with inpatient maternity, inpatient mental health services, and inpatient substance abuse services. Precertification may be required.
	Physician/surgeon fee	40% coinsurance	60% coinsurance	70% coinsurance	-----none-----

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<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$90 copay/visit	\$90 copay/visit	70% coinsurance	-----none-----
	Mental/Behavioral health inpatient services	40% coinsurance	40% coinsurance	70% coinsurance	Out-of-network: 90 days per benefit period combined with inpatient hospital, inpatient maternity, and inpatient substance abuse services. Precertification may be required.
	Substance use disorder outpatient services	\$90 copay/visit	\$90 copay/visit	70% coinsurance	-----none-----
	Substance use disorder inpatient services	40% coinsurance	40% coinsurance	70% coinsurance	Out-of-network: 90 days per benefit period combined with inpatient hospital, inpatient maternity, and inpatient mental health services. Precertification may be required.

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<b>If you are pregnant</b>	Prenatal and postnatal care	40% coinsurance	60% coinsurance	70% coinsurance	Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information.
	Delivery and all inpatient services	40% coinsurance	60% coinsurance	70% coinsurance	Out-of-network: 90 days per benefit period combined with inpatient hospital, inpatient mental health services, and inpatient substance abuse services. Precertification may be required.

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<b>If you need help recovering or have other special health needs</b>	Home health care	40% coinsurance	60% coinsurance	70% coinsurance	Combined network and out-of-network: 60 visits per benefit period.
	Rehabilitation services	40% coinsurance	60% coinsurance	70% coinsurance	Combined network and out-of-network: 30 physical medicine visits, 30 combined speech therapy and occupational therapy visits per benefit period.
	Habilitation services	40% coinsurance	60% coinsurance	70% coinsurance	
	Skilled nursing care	40% coinsurance	60% coinsurance	70% coinsurance	Combined network and out-of-network: 120 days per benefit period. Limited to 50 days out-of-network. Precertification may be required.
	Durable medical equipment	40% coinsurance	60% coinsurance	70% coinsurance	-----none-----
	Hospice service	40% coinsurance	60% coinsurance	70% coinsurance	-----none-----
<b>If your child needs dental or eye care</b>	Eye exam	No charge	No charge	Not covered	One routine eye exam every 12 months.
	Glasses	No charge	No charge	Not covered	One pair frames/lenses every 12 months.
	Dental check-up	No charge	No charge	Not covered	Two examinations every 12 months.

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**Excluded Services & Other Covered Services:**

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Hearing aids
- Routine foot care
- Bariatric surgery
- Infertility treatment
- Termination of pregnancy, except in limited circumstances
- Cosmetic surgery
- Long-term care
- Weight loss programs
- Dental care (Adult)
- Private-duty nursing

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Coverage provided outside the United States. See [www.bcbsa.com](http://www.bcbsa.com)

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## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**.

There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-510-1084. You may also contact your state insurance department at The Pennsylvania Department of Consumer Services at 1-877-881-6388.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- The Pennsylvania Department of Consumer Services at 1-877-881-6388.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

**To obtain language assistance, call 1-888-510-1084.**

SPANISH (Español): Para obtener asistencia en Español, llame al **1-888-510-1084**.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-510-1084**.

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 **1-888-510-1084**.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' **1-888-510-1084**.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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## Coverage Examples

Coverage for: Individual/Family | Plan Type: PPO

### About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is  
not a cost  
estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$1,340
- Patient pays \$6,200

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$5,500
Copays	\$0
Coinsurance	\$700
Limits or exclusions	\$0
<b>Total</b>	<b>\$6,200</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$400
- Patient pays \$5,000

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$4,600
Copays	\$400
Coinsurance	\$0
Limits or exclusions	\$0
<b>Total</b>	<b>\$5,000</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from **network providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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