Platinum

Comprehensive Care Blue PPO 500

How it works

Comprehensive Care Blue PPO 500 offers greater coverage and more predictable costs when you receive care. Here's how: Some people plan to use a lot of medical services and are willing to pay a higher monthly premium to pay less when they need care. Individuals pay 100% of the cost of most covered services until the deductible has been reached — that's $500 for individuals or $1,000 for families. Once you meet the deductible, you pay copays and coinsurance until the out-of-pocket maximum is met. After that, Highmark Health Insurance Company covers all your medical expenses when you receive covered health care services from network providers. With Comprehensive Care Blue PPO 500, your out-of-pocket maximum for the year is $1,650 for individuals or $3,300 for families.

Where to turn for help

HIGHMARK. HEALTH INSURANCE COMPANY

HighmarkBCBS.com

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Comprehensive Care Blue PPO 500 Explained

HIGHMARK. HEALTH INSURANCE COMPANY

Plan Details	Network		Out-of-Network	
	Plan Pays	You Pay[1]	Plan Pays	You Pay
Deductible – Individual	N/A	$500	N/A	$1,000
Deductible – Family[2]	N/A	$1,000	N/A	$2,000
Coinsurance plan pays after deductible	90%	10%	80%	20%
Out-of-Pocket Limit – Individual	N/A	$1,650	N/A	$3,300
Out-of-Pocket Limit – Family	N/A	$3,300	N/A	$6,600
Preventive Care[3] – Annual deductible and coinsurance do not apply to the Preventive Care services listed below				
Routine Annual Physical Exam	100%	0%	Not Covered	100%
Routine Annual Gynecological Exam	100%	0%	Not Covered	100%
Immunizations – Adult and Pediatric	100%	0%	Not Covered	100%
Routine Mammogram Screenings	100%	0%	Not Covered	100%
Preventive Medications[4]	100%	0%	Not Covered	100%
Illness or Injury Care				
Primary Care Office/Clinic Visit	90% after deductible	10% after deductible	80% after deductible	20% after deductible
Specialist Office/Urgent Care Visit	90% after deductible	10% after deductible	80% after deductible	20% after deductible
Emergency Room Visit	90% after deductible	10% after deductible	90% after in-network deductible	10% after in-network deductible
Prescription Drugs[5]	100% after copay	Generic: $5; Brand Formulary: $20; Brand Non-Formulary/Specialty: $45	Not Covered	100%
Maternity Services	90% after deductible	10% after deductible	80% after deductible	20% after deductible
Ambulance Services	90% after deductible	10% after deductible	90% after in-network deductible	10% after in-network deductible
Inpatient Hospital Services	90% after deductible	10% after deductible	80% after deductible	20% after deductible
Medical/Surgical Expenses	90% after deductible	10% after deductible	80% after deductible	20% after deductible
Diagnostic Services[6] (Lab, X-ray and other services)	90% after deductible	10% after deductible	80% after deductible	20% after deductible
Therapy and Rehabilitation Services[7]	90% after deductible	10% after deductible	80% after deductible	20% after deductible
Spinal Manipulations[8]	90% after deductible	10% after deductible	80% after deductible	20% after deductible
Skilled Nursing Facility Care	90% after deductible	10% after deductible	80% after deductible	20% after deductible
Mental Health/Substance Abuse Services	90% after deductible	10% after deductible	80% after deductible	20% after deductible
Routine Eye Exam (Every 24 months)	100%	0%	Not Covered	100%
Pediatric Dental	Exam/Cleaning: 100%; All other benefits: 50%	Exam/Cleaning: 0%; All other benefits: 50%	Not Covered	100%
Pediatric Vision	Exam: 100%; Frames/Lenses: 100%	Exam: 0%; Frames/Lenses: 0%	Not Covered	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]Shared Cost and Comprehensive Care Family Deductible: 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.

[8]Spinal manipulations are limited to 20 services per contract year in and out-of-network.

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