Gold

Shared Cost Blue EPO 0

How it works

Shared Cost Blue EPO 0 helps keep your monthly expenses lower and offers fixed copays for some services. Here's how: Many people don't expect to use a lot of medical services but want fixed, predictable costs when they get care. With Shared Cost Blue EPO 0, members have a fixed copay for some services, like doctor visits. You pay copays and coinsurance until you reach the out-of-pocket maximum for the year. That amount is $5,000 for individuals or $10,000 for families. Then, Blue Cross Blue Shield Delaware covers all your medical expenses when you receive covered health care services from network providers.

Where to turn for help

HIGHMARK. Delaware

HighmarkBCBSDE.com

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Shared Cost Blue EPO 0 Explained

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Plan Details	Network		Out-of-Network	
	Plan Pays	You Pay[1]	Plan Pays	You Pay
Deductible – Individual	N/A	$0	N/A	N/A
Out-of-Pocket Limit – Individual	N/A	$5,000	N/A	N/A
Deductible – Family[2]	N/A	$0	N/A	N/A
Out-of-Pocket Limit – Family	N/A	$10,000	N/A	N/A
Coinsurance plan pays after deductible	80%	20%	N/A	N/A
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	100% after copay	$35 copay	Not Covered	100%
Specialist Office Visit	100% after copay	$50 copay	Not Covered	100%
Emergency Room Visit	100% after copay	$250 copay	100% after copay	$250 copay
Urgent Care Visit	100% after copay	$50 copay	Not Covered	100%
Prescription Drugs[5]	100% after copay	Generic: $8 copay; Brand Formulary: $35 copay; Brand Non-Formulary/Specialty: $50 copay	Not Covered	100%
Maternity Services	80%	20%	Not Covered	100%
Ambulance Services	80%	20%	80%	20%
Inpatient Hospital Services	100% after copay	$500 copay for 5 days, then 100% thereafter	Not Covered	100%
Medical/Surgical Expenses	80%	20%	Not Covered	100%
Diagnostic Services[6] (Lab, X-ray and other services)	100% after copay	Lab: $25 copay; Diagnostic: $35 copay; Advanced Imaging: $250 copay	Not Covered	100%
Therapy and Rehabilitation Services[7]	100% after copay	$50 copay	Not Covered	100%
Spinal Manipulations[8]	80%	20%	Not Covered	100%
Skilled Nursing Facility Care	80%	20%	Not Covered	100%
Mental Health Services	Outpatient: 100% after copay; Inpatient: 80%	Outpatient: $50 copay; Inpatient: 20%	Not Covered	100%
Substance Abuse – Rehabilitation	Outpatient: 100% after copay; Inpatient: 80%	Outpatient: $50 copay; Inpatient: 20%	Not Covered	100%
Substance Abuse – Detoxification	80%	20%	Not Covered	100%
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 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 Delaware 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] Prescription drug copays for a 31-day supply (Retail): $8 generic; $35 brand; $50 non-formulary brand, non-formulary generic and specialty. The plan utilizes the HCR Comprehensive Formulary on the Premier network. Mail order available.

[6] Laboratory and Diagnostic Services require one copay per date of service and type of service. Advanced Imaging includes but is 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 each for Rehabilitative and Habilitative services (60 visits total per contract year). Speech therapy and occupational therapy are a combined 30 visit limit per contract year each for Rehabilitative and Habilitative services (60 visits total per contract year).

[8] Spinal manipulations are limited to 30 services per contract year.

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