Gold

Shared Cost Blue PPO 1000

How it works

Shared Cost Blue PPO 1000 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 PPO 1000, members have a fixed copay for some services, like doctor visits, prior to meeting the deductible. For less common services, individuals pay 100% of costs of most covered services until the deductible of $1,000 for individuals or $2,000 for families has been reached. After that, you pay copays and coinsurance until you reach the out-of-pocket maximum for the year. That amount is $3,500 for individuals or $7,000 for families. Then, Blue Cross Blue Shield West Virginia covers all your medical expenses when you receive covered health care services from network providers.

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Shared Cost Blue PPO 1000 Explained

Highmark West Virginia

Plan Details	Network		Out-of-Network	
	Plan Pays	You Pay[1]	Plan Pays	You Pay
Deductible – Individual	N/A	$1,000	N/A	$2,000
Out-of-Pocket Limit – Individual	N/A	$3,500	N/A	$7,000
Deductible – Family[2]	N/A	$2,000	N/A	$4,000
Out-of-Pocket Limit – Family	N/A	$7,000	N/A	$14,000
Coinsurance plan pays after deductible	80%	20%	60%	40%
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	60% after deductible	40% after deductible
Specialist Office Visit	100% after copay	$45 copay	60% after deductible	40% after deductible
Emergency Room Visit	80% after copay	20% after $150 copay	80% after copay	20% after $150 copay
Urgent Care Visit	100% after copay	$45 copay	60% after deductible	40% after deductible
Prescription Drugs[5]	100% after copay	Generic: $8 Brand: $45	Not Covered	100%
Maternity Services	80% after deductible	20% after deductible	60% after deductible	40% after deductible
Ambulance Services	80% after deductible	20% after deductible	80% after in-network deductible	20% after in-network deductible
Inpatient Hospital Services	80% after deductible	20% after deductible	60% after deductible	40% after deductible
Medical/Surgical Expenses	80% after deductible	20% after deductible	60% after deductible	40% after deductible
Diagnostic Services[6] (Lab, X-ray and other services)	80% after deductible	20% after deductible	60% after deductible	40% after deductible
Therapy and Rehabilitation Services[7]	80% after deductible	20% after deductible	60% after deductible	40% after deductible
Spinal Manipulations	80% after deductible	20% after deductible	60% after deductible	40% after deductible
Skilled Nursing Facility Care	80% after deductible	20% after deductible	60% after deductible	40% after deductible
Mental Health Services	Outpatient: 100% after copay; Inpatient: 80% after deductible	Outpatient: $35 copay; Inpatient: 20% after deductible	60% after deductible	40% after deductible
Substance Abuse – Rehabilitation	Outpatient: 100% after copay; Inpatient: 80% after deductible	Outpatient: $35 copay; Inpatient: 20% after deductible	60% after deductible	40% after deductible
Substance Abuse – Detoxification	80% after deductible	20% after deductible	60% after deductible	40% after deductible
Routine Eye Exam (Every 12 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[8]	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 West Virginia 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 34-day supply (Retail): $8 generic; $45 brand; $95 non-formulary brand and non-formulary generic; specialty drug copays vary. The plan has a four-tier structure and utilizes the HCR Progressive 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 copay 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 Therapy, Occupational Therapy and Chiropractic Care are limited to 30 visits for each benefit per contract year for Rehabilitative and Habilitative services (combined).

[8] Vision benefits utilize the Davis National Network. Pediatric Dental benefits utilize United Concordia's Advantage Plus Network.

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