

Summary of Benefits and Coverage: What this Plan² Covers & What it Costs



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 capbluecross.com or by calling 1-800-962-2242.

| Important Questions | Answers | Why this Matters: |
|--|--|---|
| What is the overall deductible? | \$1,300/person/\$2,600/family. Deductible applies to all services, including prescription drug, before any copayment or coinsurance are applied. Doesn't apply to network preventive services. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| Is there an out-of-pocket limit on my expenses? | Yes, \$6,450/person/\$12,900/family ; combined out-of-pocket limit for medical and prescription drug. | The out-of-pocket limit 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. |
| What is not included in the out-of-pocket limit? | Pre-authorization penalties, premium, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits. |
| Does this plan use a network of providers? | Yes. For a list of participating providers, see capbluecross.com or call 1-800-962-2242. | If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays for different kinds of providers . |
| Do I need a referral to see a specialist? | No. You don't need a referral to see a specialist. | You can see the specialist you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services . |

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Administered by Capital BlueCross¹

PPO H S A/with drug

Coverage Period: 1/1/2015 - 12/31/2015

Coverage for: All | Plan Type: PPO HSA

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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 an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network 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 participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|--|-----------------------------------|----------------------------------|---|
| | | Participating Provider | Non-Participating Provider | |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$20 copay/visit | 20% coinsurance | -----none----- |
| | Specialist visit | \$30 copay/visit | 20% coinsurance | |
| | Other practitioner office visit | \$30 copay/visit for chiropractic | 20% coinsurance for chiropractic | Acupuncture not covered. Chiropractic not covered after 20 visits. |
| | Preventive care / screening / immunization | No charge | 20% coinsurance | Deductible does not apply to services at participating providers. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge for lab or tests. | 20% coinsurance | -----none----- |
| | Imaging (CT / PET scans, MRIs) | No charge | 20% coinsurance | Preauthorization is required. ³ |

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| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|--|--|---|----------------------------|--|
| | | Participating Provider | Non-Participating Provider | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at capbluecross.com | Generic drugs | 25% coinsurance (retail prescription) \$25 copay (mail order prescription) | | Covers up to 30-day supply (retail prescription) 90-day supply (mail order prescription) |
| | Preferred brand drugs | 25% coinsurance (retail prescription) \$75 copay (mail order prescription) | | |
| | Non-preferred brand drugs | 45% coinsurance (retail prescription) \$125 copay (mail order prescription) | | |
| | Specialty drugs | 25% coinsurance (generic) 25% coinsurance (preferred) 25% coinsurance (non-preferred) | | Prescription written for up to 30 days supply. \$150 maximum copay (generic) \$150 maximum copay (preferred brand) \$150 maximum copay (non-preferred brand) |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 50% coinsurance | Services at non-participating ambulatory surgical facilities not covered. |
| | Physician / surgeon fees | No charge | 20% coinsurance | Preauthorization is required. ³ |
| If you need immediate medical attention | Emergency room services | \$100 copay/service | \$100 copay/service | Copay waived if admitted. |
| | Emergency medical transportation | No charge | No charge | -----none----- |
| | Urgent care | \$50 copay/service | 20% coinsurance | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 50% coinsurance | Preauthorization is required. ³ |
| | Physician / surgeon fees | No charge | 20% coinsurance | -----none----- |

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³ Preauthorization may apply. See your contract for a list of services requiring Preauthorization and penalties for failure to obtain Preauthorization.

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|---|--|------------------------|----------------------------|---|
| | | Participating Provider | Non-Participating Provider | |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$30 copay/visit | 20% coinsurance | -----none----- |
| | Mental/Behavioral health inpatient services | No charge | 50% coinsurance | -----none----- |
| | Substance use disorder outpatient services | No charge | 20% coinsurance | -----none----- |
| | Substance use disorder inpatient services | No charge | 50% coinsurance | -----none----- |
| If you are pregnant | Prenatal and postnatal care | No charge | 20% coinsurance | -----none----- |
| | Delivery and all inpatient services | No charge | 50% coinsurance | -----none----- |
| If you need help recovering or have other special health needs | Home health care | No charge | 20% coinsurance | After 90 visits, not covered. Preauthorization is required. ³ |
| | Rehabilitation services | \$30 copay/visit | 20% coinsurance | Therapy limited to 30 visits |
| | Habilitation services | Not covered | Not covered | -----none----- |
| | Skilled nursing care | No charge | 50% coinsurance | After 100 days, not covered. |
| | Durable medical equipment | No charge | 20% coinsurance | Preauthorization required on items greater than or equal to \$500. ³ |
| | Hospice service | No charge | 20% coinsurance | -----none----- |
| If your child needs dental or eye care | Eye exam | Not covered | Not covered | -----none----- |
| | Glasses | Not covered | Not covered | -----none----- |
| | Dental check-up | Not covered | Not covered | -----none----- |

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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 | • Bariatric surgery (unless medically necessary) | • Cosmetic surgery |
| • Dental care | • Glasses | • Habilitation services |
| • Hearing aids | • Long-term care | • Private-duty nursing |
| • Routine eye care | • Routine foot care | • Weight loss programs |

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

- | | | |
|--|---------------------|--|
| • Chiropractic care | • Infertility | Most coverage provided outside the United States. |
| • Non-emergency care when traveling outside the U.S. | • Routine maternity | • See www.bcbs.com/shop-for-health-insurance/coverage-home-and-away.html |

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-962-2242. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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: Capital BlueCross at 1-800-962-2242. You may also contact the Pennsylvania Insurance Department at 1-877-881-6388 or www.insurance.pa.gov. If your group is subject to ERISA, you may contact the Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For additional assistance, you may contact the Pennsylvania consumer assistance line at 1-877-881-6388 or ra-in-consumer@state.pa.us.

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-962-2242.

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

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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 also will be different.

See the next page for Important information about these examples.

Having a Baby
(normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,030
- Patient pays \$1,510

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 |

| | |
|--------------|----------------|
| Total | \$7,540 |
|--------------|----------------|

Patient pays:

| | |
|----------------------|---------|
| Deductibles | \$1,300 |
| Copays | \$0 |
| Coinsurance | \$10 |
| Limits or exclusions | \$200 |

| | |
|--------------|----------------|
| Total | \$1,510 |
|--------------|----------------|

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

- Amount owed to providers: \$5,400
- Plan pays \$3,120
- Patient pays \$2,280

Sample care costs:

| | |
|--------------------------------|---------|
| Prescriptions | \$2,900 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits & Procedures | \$700 |
| Education | \$300 |
| Laboratory tests | \$100 |
| Vaccines, other preventive | \$100 |

| | |
|--------------|----------------|
| Total | \$5,400 |
|--------------|----------------|

Patient pays:

| | |
|----------------------|---------|
| Deductibles | \$1,300 |
| Copays | \$0 |
| Coinsurance | \$900 |
| Limits or exclusions | \$80 |

| | |
|--------------|----------------|
| Total | \$2,280 |
|--------------|----------------|

Note: These numbers do NOT assume the patient is participating in our diabetes wellness program. If you have diabetes and participate in the wellness program, your costs may be lower. For more information about the diabetes wellness program, please contact us at 1-800-892-3033.

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 to 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 in-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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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.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

- 1** Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.
- 2** Member cost share may be reduced by employer participation in an HRA (Health Reimbursement Account), HSA (Health Savings Account), or FSA (Flexible Spending Account).

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