Blue Cross of NEPA: Blast Intermediate Unit 17

Coverage Period: 07/01/2014 - 06/30/2015

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.bcnepa.com or by calling 1-888-338-2211.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	Individual $250/Family $750 Preferred Provider, Individual $500/Family $1500 Non-Preferred Provider per Calendar Year; doesn't apply to preventive care or ER services. Consult your policy for other services not applied to deductible.	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 Common Medical Event chart for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No, there are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services, but see the Common Medical Event chart for other costs for services this plan covers.
Is there an **out-of-pocket limit** on my expenses?	Coinsurance Maximum-Individual $1,500/Family $4,500 Preferred Provider, Individual $3,000/Family $9,000 Non-Preferred Provider. Out-of-pocket limit Individual $6,350/Family $12,700 Preferred Provider. No Out-of-Pocket limit on Non-Preferred Provider.	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. If you are also covered by an integrated health FSA, HRA, and/or HSA, you may have access to additional funds to help cover certain out-of-pocket expenses, such as **deductibles**, co-payments, or co-insurance.
What is not included in the **out-of-pocket limit**?	Premiums, penalties, balance-billed charges and amounts for non-covered services.	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 Common Medical Event chart describes any limits on what the plan will pay for specific services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. See www.bcnepa.com or call 1-888-338-2211 for a list of participating providers.	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 Common Medical Event chart for how this plan pays different kinds of **providers**.

Questions: Call 1-888-338-2211 or visit www.bcnepa.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.bcnepa.com/sbcglossary or call 1-888-338-2211 to request a copy.

Important Questions	Answers	Why this Matters:
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 the **excluded services** chart. See your policy or plan document for additional information about **excluded services**.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is you share of the costs of 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 co-insurance 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
		Preferred	Non-Preferred	
If you visit a health care **provider's office or clinic**	Primary care visit to treat an injury or illness	$20 copayment/visit	40% coinsurance	None
	Specialist visit	$40 copayment/visit	40% coinsurance	None
	Other practitioner office visit	$40 copayment	40% coinsurance	Chiropractic benefits: Limited to 12 visits per Calendar Year age 13 and up.
	Preventive care/screening/immunization	0% coinsurance	40% coinsurance	None
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT, PET scans, MRIs)	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred	Non-Preferred	
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at **www.bcnepa.com**	Retail drugs	$0/$10/$20/$35	Not covered	If you have prescription coverage - plan covers up to a 30-day supply (retail prescription)
	Mail Order drugs	$0/$20/$40/$105	Not covered	If you have prescription coverage - plan covers 31-90 day supply (mail order prescription)
	Speciality drugs	Not covered	Not covered	None
If you have outpatient surgery	Facility fee (eg. ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room services	$50 copayment	$50 copayment	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$40 copayment	40% coinsurance	None
If you have a hospital stay	Facility fee (eg. hospital room)	20%	40%	None
	Physician/surgeon fee	20% coinsurance	40% coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	None
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	None
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	None
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	None

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred	Non-Preferred	
If you are pregnant	Prenatal and postnatal care	No charge Prenatal; 20% coinsurance postnatal	40% coinsurance	None
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	None
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical Therapy (20 visits), Speech Therapy (12 visits), Occupational Therapy (12 visits) per Calendar Year
	Habilitation services	Not covered	Not covered	No coverage is provided for habilitation services.
	Skilled nursing care	20% coinsurance	40% coinsurance	60 days per Calendar Year
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice service	20% coinsurance	40% coinsurance	180 days per lifetime.
If your child needs dental or eye care	Eye exam	20% coinsurance	40% coinsurance	Limited to coverage for eye exam provided as part of preventive pediatric exam.
	Glasses	20% coinsurance	40% coinsurance	Coverage limited to glasses which perform function of a human lens lost as a result of ocular surgery or injury, and when prescribed in lieu of surgery for certain conditions.
	Dental check-up	Not covered	Not covered	No coverage is provided for dental check-up.

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.)

- Cosmetic Surgery
- Habilitation Services

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.)

- Coverage provided when traveling outside the U.S. See www.bcnepa.com

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 1-888-338-2211. 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.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: 1-888-338-2211. Complaint and grievance procedures have been established for your use if you are in any way dissatisfied with Blue Cross, a practitioner or a provider. You may call 1-888-338-2211 in order to informally resolve the matter. If not resolved to your satisfaction, you can file a formal complaint or grievance with us within 180 days from the date of denial or incident. A full explanation of your appeal rights are outlined in your member materials.

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 not 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 not meet the minimum value standard for the benefits it provides.**

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

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.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,730
- **Patient pays:** $1,810

Sample Care Costs

Hospital charge (mother)	$2,700
Routine obstetic 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	$250
Co-pays	$0
Co-insurance	$1,410
Limits or exclusions	$150
Total	**$1,810**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,647
- **Patient pays:** $753

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
Total	**$5,400**

Patient Pays

Deductibles	$250
Co-pays	$160
Co-insurance	$238
Limits or exclusions	$105
Total	**$753**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please call 1-888-338-2211.

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 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 for 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 **co-payments, 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.