Capital BLUE

Healthy Benefits PPO HSA 3000.10 STD

Coverage Period: Beginning on or after 1/1/2016

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

Coverage for: All **| Plan Type:** PPO HSA

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 **https://www.capbluecross.com/sbcsia** or by calling **1-800-730-7219**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000**/person/**$6,000**/family participating providers **$5,000**/person/**$10,000**/family non-participating providers. **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?	Yes, $75/person for pediatric dental. There are no other specific deductibles.	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, **$4,000**/person/**$8,000**/family/participating providers **$10,000**/person/**$20,000**/family/non-participating providers; 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, premiums, 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 *specific* 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 1-800-730-7219.	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**.

Questions: Call **1-800-730-7219** or visit us at **capbluecross.com**. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call **1-800-730-7219** to request a copy.

- **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 provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	50% coinsurance	----------none----------
	Specialist visit	10% coinsurance	50% coinsurance	
	Other practitioner office visit	10% coinsurance for chiropractic	50% coinsurance for chiropractic	Acupuncture not covered. Chiropractic not covered after 20 visits.
	Preventive care / screening / immunization	No charge	50% coinsurance	Deductible does not apply to services at participating providers.
If you have a test	Diagnostic test (x-ray, blood work)	10% for x-ray; 10% coinsurance for lab services at stand alone & hospital owed labs.	50% coinsurance	----------none----------
	Imaging (CT / PET scans, MRIs)	10% coinsurance	50% coinsurance	Preauthorization is required.[2]

Common Medical Event	Services You May Need	Your Cost If You Use A Participating Provider	Your Cost If You Use A Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at capbluecross.com	Generic drugs	10% coinsurance (retail prescription) 10% coinsurance (mail order prescription)		Mandatory Generic Substitution Program applies. Pharmacies that participate in the Advanced Choice Network provide the highest level of coverage for retail drugs.Out of Network =50% coinsurance.
	Preferred brand drugs	10% coinsurance (retail prescription) 10% coinsurance (mail order prescription)		
	Non-preferred brand drugs	10% coinsurance (select non-preferred) (retail and mail order prescription)		
	Specialty drugs	10% coinsurance (generic and select non- preferred brand) $285 copay (preferred brand) prescription		Only select non-preferred drugs will be covered. Mandatory Generic Substitution Program applies.Out of Network=50% coinsurance.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	Services at non-participating ambulatory surgical facilities not covered.
	Physician / surgeon fees	10% coinsurance	50% coinsurance	Preauthorization is required.[2]
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	----------none----------
	Emergency medical transportation	10% coinsurance	10% coinsurance	----------none----------
	Urgent care	10% coinsurance	10% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Preauthorization is required.[2]
	Physician / surgeon fees	10% coinsurance	50% coinsurance	----------none----------

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

Common Medical Event	Services You May Need	Your Cost If You Use A		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	50% coinsurance	----------none----------
	Mental/Behavioral health inpatient services	10% coinsurance	50% coinsurance	----------none----------
	Substance use disorder outpatient services	10% coinsurance	50% coinsurance	----------none----------
	Substance use disorder inpatient services	10% coinsurance	50% coinsurance	----------none----------
If you are pregnant	Prenatal and postnatal care	No Charge	50% coinsurance	Deductible does not apply to services at participating providers.
	Delivery and all inpatient services	10% coinsurance	50% coinsurance	----------none----------
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	After 60 visits, not covered. Preauthorization is required.[2]
	Rehabilitation services	10% coinsurance	50% coinsurance	Visit Limit: Physical & occupational 60 combined;speech 60; (combined w/habilitative);respiratory 20
	Habilitation services	10% coinsurance	50% coinsurance	Visit Limit: Physical & occupational 60 combined; speech 60; (combined w/rehabilitative)
	Skilled nursing care	10% coinsurance	50% coinsurance	After 120 days, not covered.
	Durable medical equipment	10% coinsurance	50% coinsurance	Preauthorization required on items greater than or equal to $500.[2]
	Hospice service	10% coinsurance	50% coinsurance	----------none----------
If your child needs dental or eye care	Eye exam	No charge	Balance of retail charge after the following allowances: Exam $32; Frames $30; Lenses: Single $24; Bifocal $36; Trifocal $46	Limited to one exam and one pair of glasses per year.
	Glasses	No charge for standard frames and lenses. See plan document for non-standard frame benefits.		
	Dental check-up	No charge	20% coinsurance	Deductible does not apply

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

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 (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (unless medically necessary)
- Termination of pregnancy, except in limited circumstances
- 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
- Most coverage provided outside the United States. See www.bcbs.com/already-a-member/traveling-outside-of-the.html
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**.

There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the state
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-730-7219. You may also contact your state insurance department at 1-877-881-6388 or ra-in-consumer@state.pa.us.

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 1-800-730-7219. 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 Espanol, llame al 1-800-730-7219.

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** $3,940
- **Patient pays** $3,600

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	$3,000
Copays	$0
Coinsurance	$400
Limits or exclusions	$200
Total	**$3,600**

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

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

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	$3,000
Copays	$0
Coinsurance	$200
Limits or exclusions	$80
Total	**$3,280**

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 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 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.

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.**

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.