



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.bcbst.com/sbc/2016/127600/S04S_policy.pdf or by calling 1-800-565-9140.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	In-network: \$2,000 person/ \$4,000 family Out-of-network: \$4,000 person/ \$8,000 family Doesn't apply to in-network preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network: \$4,000 person/ \$8,000 family Out-of-network: \$12,000 person/ \$24,000 family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u>?	Premium, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>network of providers</u>?	Yes. For a list of <u>in-network providers</u> , see www.bcbst.com or call 1-800-565-9140.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> 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 6. See your policy or plan document for additional information about <u>excluded services</u> .

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Questions: Call 1-800-565-9140 or visit us at www.bcbst.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 1-800-565-9140 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **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 in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	50% co-insurance	50% co-insurance	_____none_____
	Specialist visit	50% co-insurance	50% co-insurance	_____none_____
	Other practitioner office visit	50% co-insurance	50% co-insurance	Therapy limited to 20 visits per type per Calendar Year. Cardiac/Pulmonary Rehab limited to 36 visits per type per Calendar Year.
	Preventive care/screening/immunization	No Charge	50% co-insurance	1 visit per Calendar Year
If you have a test	Diagnostic test (x-ray, blood work)	50% co-insurance	50% co-insurance	_____none_____
	Imaging (CT/PET scans, MRIs)	50% co-insurance	50% co-insurance	Prior Authorization required. Penalties include reduced benefits or denial of claim.
If you need drugs to treat your illness or condition	Generic drugs	50% co-insurance	50% co-insurance	30-day supply retail; up to 90 day supply home delivery or Select90 Network.
More information about	Preferred brand drugs	50% co-insurance	50% co-insurance	Any copayment listed is per 30-day supply. Prescription drugs are available in a 30-day supply at retail pharmacies and up to a 90-day supply via Mail Order Network and Select90 Network.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
<u>prescription drug coverage</u> is available at www.bcbst.com .	Non-preferred brand drugs	50% co-insurance	50% co-insurance	Any copayment listed is per 30-day supply. Prescription drugs are available in a 30-day supply at retail pharmacies and up to a 90-day supply via Mail Order Network and Select90 Network.
	Self-administered specialty drugs	50% co-insurance at specialty pharmacy network	Not Covered	Must use a pharmacy in Specialty pharmacy network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% co-insurance	50% co-insurance	Prior Authorization required for certain outpatient procedures. Penalties include reduced benefits or denial of claim.
	Physician/surgeon fees	50% co-insurance	50% co-insurance	Prior Authorization required for certain outpatient procedures. Penalties include reduced benefits or denial of claim.
If you need immediate medical attention	Emergency room services	50% co-insurance	50% co-insurance	_____none_____
	Emergency medical transportation	50% co-insurance	50% co-insurance	_____none_____
	Urgent care	50% co-insurance	50% co-insurance	Urgent Care benefits are determined by place of service. Benefits displayed are for urgent care services received at a physician's office.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% co-insurance	50% co-insurance	Prior Authorization for Covered Services must be obtained or benefits will be reduced or denied.
	Physician/surgeon fee	50% co-insurance	50% co-insurance	Prior Authorization for Covered Services must be obtained or benefits will be reduced or denied.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	50% co-insurance	50% co-insurance	Prior Authorization required for certain outpatient procedures. Penalties include reduced benefits or denial of claim.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Mental/Behavioral health inpatient services	50% co-insurance	50% co-insurance	Prior Authorization required. Penalties include reduced benefits or denial of claim.
	Substance use disorder outpatient services	50% co-insurance	50% co-insurance	Prior Authorization required for certain outpatient procedures. Penalties include reduced benefits or denial of claim.
	Substance use disorder inpatient services	50% co-insurance	50% co-insurance	Prior Authorization required. Penalties include reduced benefits or denial of claim.
If you are pregnant	Prenatal and postnatal care	50% co-insurance	50% co-insurance	Prior Authorization for Covered Services must be obtained or benefits will be reduced or denied.
	Delivery and all inpatient services	50% co-insurance	50% co-insurance	Prior Authorization for Covered Services must be obtained or benefits will be reduced or denied.
If you need help recovering or have other special health needs	Home health care	50% co-insurance	50% co-insurance	Limited to 60 visits per Calendar Year
	Rehabilitation services	50% co-insurance	50% co-insurance	Therapy limited to 20 visits per type per Calendar Year.
	Habilitation services	50% co-insurance	50% co-insurance	Cardiac/Pulmonary Rehab limited to 36 visits per Calendar Year.
	Skilled nursing care	50% co-insurance	50% co-insurance	Skilled Nursing and Rehabilitation Facility limited to 60 days combined per Calendar Year.
	Durable medical equipment	50% co-insurance	50% co-insurance	Certain durable medical equipment requires Prior Authorization. Penalties include reduced benefits or denial of claim.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Hospice service	No Charge	50% co-insurance	Medically Necessary and Appropriate services and supplies for supportive care where life expectancy is six months or less. Prior Authorization for inpatient hospice must be obtained or benefits will be reduced or denied.
If your child needs dental or eye care	Eye exam	No Charge	40% co-insurance	1 visit per Calendar Year. Does not apply to deductible.
	Glasses	No Charge	40% co-insurance	1 item per Calendar Year. Does not apply to deductible.
	Dental check-up	No Charge	No Charge	1 visit per 6 months

Language Access Services:

Spanish (Español): Para obtener ayuda en español, llame al **1-800-565-9140**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-565-9140**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-800-565-9140**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1-800-565-9140**.

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](#).)

- Abortion, except services for which federal funding is allowed
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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 and your costs for these services.)

- Chiropractic care
- Hearing aids
- 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 **1-800-565-9140**. You may also contact your state insurance department at **1-800-342-4029**.

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 your state insurance department at **1-800-342-4029**. Additionally, a consumer assistance program can help you file your appeal. Contact **1-800-342-4029**.

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.**

—————*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 \$3,510
- Patient pays \$4,030

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	\$2,000
Copays	\$0
Co-insurance	\$2,000
Limits or exclusions	\$30
Total	\$4,030

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

- Amount owed to providers: \$5,400
- Plan pays \$1,900
- Patient pays \$3,500

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	\$2,000
Copays	\$0
Co-insurance	\$1,500
Limits or exclusions	\$0
Total	\$3,500

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 **co-insurance** 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 **co-insurance**. 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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