Highmark Blue Cross Blue Shield: myBlue Access $1,500

Coverage Period: 01/01/2016 - 12/31/2016

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

Coverage for: Individual + Family | **Plan Type:** Custom 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.highmarkbcbs.com or by calling 1-888-510-1064.

Important Questions	Answers	Why this Matters:
What is the overall **deductible?**	Individual $1,500/Family $3,000 Preferred Provider, Individual $6,000/Family $12,000 Non-Preferred Provider per Calendar Year; doesn't apply to preventive care. 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. 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?	Individual $6,600/Family $13,200 Preferred Provider, Individual $10,000/Family $20,000 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, 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.highmarkbcbs.com or call 1-888-510-1064 for a list of participating providers.	If you use a Preferred Provider doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your Preferred Provider doctor or hospital may use a Non-Preferred Provider **provider** for some services. Plans use the term Preferred Provider, **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 1-888-510-1064 or visit us at www.highmarkbcbs.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.dol.gov/ebsa/healthreform and www.HealthCare.gov or call 1-888-510-1064 to request a copy.
A copy of your agreement can be found at https://shop.highmark.com/sales/#!/sbc-agreements.

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 *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 a Non-Preferred Provider **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a Non-Preferred Provider 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 Preferred Provider	Your Cost if You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care **provider's office or clinic**	Primary care visit to treat an injury or illness	$40 copayment	50% coinsurance	Non-Preferred deductible applies
	Specialist visit	$60 copayment	50% coinsurance	Non-Preferred deductible applies
	Other practitioner office visit	$60 copayment	50% coinsurance	Non-Preferred deductible applies
	Preventive care Screening Immunization	No charge	50% coinsurance	None

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Provider	Your Cost if You Use a Non-Preferred Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	$40 copayment	50% coinsurance	Copay only applies to labs and xrays are subject to the deductible and coinsurance
	Imaging (CT/PET scans, MRIs)	$75 copayment/test	50% coinsurance	Non-Preferred deductible applies
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at 1-888-510-1064.	Retail Drugs	$3/$25/$50/$75 copayment	Not covered	Prescription coverage - plan covers up to a 30-day supply (retail prescription)
	Mail Order drugs	$6/$50/$100/$150 copayment	Not covered	Prescription coverage - plan covers 31-90-day supply (mail order prescription)
	Speciality drugs	50% up to $2,500 for individual and $5,000 for family	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Deductible applies
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Deductible applies
If you need immediate medical attention	Emergency room services	$150 copayment	$150 copayment	None
	Emergency medical transportation	$150 copayment	$150 copayment	None
	Urgent care	$60 copayment	50% coinsurance	Non-Preferred deductible applies
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Deductible applies
	Physician/surgeon fee	20% coinsurance	50% coinsurance	Deductible applies

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Provider	Your Cost if You Use a Non-Preferred Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$60 copayment	50% coinsurance	Non-Preferred deductible applies
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	Deductible applies
	Substance use disorder outpatient services	$60 copayment	50% coinsurance	Non-Preferred deductible applies
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	Deductible applies
If you are pregnant	Prenatal and postnatal care	No charge	50% coinsurance	Deductible only applies to Non-Preferred Provider.
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Deductible (if any) applies
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	60 visits per benefit period. Deductible applies.
	Rehabilitation services	$60 copayment	50% coinsurance	Physical and Occupational Therapy (30 visits combined); Speech Therapy (30 visits) per Calendar Year. Deductible applies
	Habilitation services	$60 copayment	50% coinsurance	Physical and Occupational Therapy (30 visits combined); Speech Therapy (30 visits) per Calendar Year. Deductible applies
	Skilled nursing care	20% coinsurance	50% coinsurance	120 days per benefit period. Deductible applies
	Durable medical equipment	50% coinsurance	50% coinsurance	Deductible applies
	Hospice service	20% coinsurance	50% coinsurance	Deductible applies

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Provider	Your Cost if You Use a Non-Preferred Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No charge	Not covered	One exam/benefit year to age 19
	Glasses	No charge	Not covered	One pair glasses (lenses & frames) or contacts per 12 month period. Covered to age 19.
	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.)

- Abortions, except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the life of the woman in danger unless an abortion is performed
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental Check-Up (Pediatric)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Orthotics
- Private-Duty Nursing
- 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.)

- Cardiac rehabilitation (36 visits)
- Chiropractic care (20 visits) age 13 and up
- Coverage provided when traveling outside the U.S. See www.bcbsa.com
- Pulmonary therapy (18 visits)
- Respiratory therapy (18 visits)

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 1-888-510-1064. You may also contact your state insurance department at 1-877-881-6388.

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:

- The Pennsylvania Department of Consumer Services at 1-877-881-6388.

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 establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). T**his health coverage does meet the minimum value standard for the benefits it provides.**

To obtain language assistance, call 1-888-510-1064.

SPANISH (Español): Para obtener asistencia en Español, llame al **1-888-510-1064**.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-510-1064**.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 **1-888-510-1064**.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-888-510-1064**.

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** $4,730
- **Patient pays** $2,810

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	$1,500
Copays	$0
Coinsurance	$1,160
Limits or exclusions	$150
Total	**$2,810**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,575
- **Patient pays** $1,825

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	$1,440
Copays	$280
Coinsurance	$0
Limits or exclusions	$105
Total	**$1,825**

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.

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 Preferred Provider **providers**. If the patient had received care from Non-Preferred Provider **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.