Summary of Benefits and Coverage

In this booklet, you will find the Summary of Benefits and Coverage Document for the 2018 Gore PPO Medical/Prescription Plan administered by Highmark Blue Cross Blue Shield and Express Scripts. This SBC, required by the Patient Protection and Affordable Care Act (more commonly known as the Health Care Reform Act), is designed to help you better understand and evaluate your health insurance choices.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, at www.highmarkbcbsde.com or by calling 1-800-345-4593.For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbcglossary or call 1-800-238-3488 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $500 individual / $1,000 family For out-of-network providers $1,000 individual / $2,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $2,000 individual / $3,500 family For out-of-network providers $4,000 individual / $6,000 family For prescription drug expenses $3,000 individual / $4,500 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing 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
Will you pay less if you use a network provider?	Yes. See www.highmarkbcbsde.com or call 1-800-345-4593 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

* For more information about limitations and exceptions, see the plan or policy document at www.highmarkbcbsde.com.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay /visit, deductible waived	40% coinsurance	----------none----------
	Specialist visit	$25 copay/visit, deductible waived	40% coinsurance	Coverage is limited to 30 visits per calendar year for Chiropractic Care
	Preventive care/screening/ immunization	No charge, deductible waived	40% coinsurance	Coverage is limited by age, gender and risk parameters as identified in Highmark Delaware's Preventive Health Care Guidelines. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	40% coinsurance	Subject to medical necessity
	Imaging (CT/PET scans, MRIs)	25% coinsurance	40% coinsurance	Subject to medical necessity
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com or by calling 1-888-792-7265.	Generic drugs (Tier 1)	Retail: $10 Copay Mail Order: $20 Copay	Same as In-Network; Must pay full price at retail pharmacy and submit a paper claim for reimbursement	For retail pharmacy you can receive up to a 34 day supply, for mail order you can receive up to a 90 day supply. Some drugs require prior authorization and/or have quantity limits. If necessary pre-authorization is not obtained, the drug may not be covered. Certain preventative care drugs are covered at 100%.
	Preferred brand drugs (Tier 2)	Retail: $30 Copay Mail Order: $60 Copay		
	Non-preferred brand drugs (Tier 3)	Retail: $50 Copay Mail Order: $100 Copay		
	Specialty drugs (Tier 4)	$50 Copay for Preferred and Non-Preferred bands		For retail pharmacy you can receive up to a 30 day supply one time. For additional fills, specialty prescriptions must be filled through Accredo ESI's Specialty Pharmacy. You may reach Accredo by calling 1-800-803-2523.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	40% coinsurance	Preauthorization is required for some services.
	Physician/surgeon fees	25% coinsurance	40% coinsurance	Preauthorization is required for some services.
If you need immediate medical attention	Emergency room care	$100 copay/visit, deductible waived	$100 copay/visit, deductible waived	Copay waived if admitted as an inpatient. Applicable coinsurance and copays apply when additional services are rendered.
	Emergency medical transportation	$50 copay/occurrence, deductible waived	$50 copay/occurrence, deductible waived	None
	Urgent care	$35 copay/visit, deductible waived	$35 copay/visit, deductible waived	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	25% coinsurance	40% coinsurance	Preauthorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay /visit, deductible waived	40% coinsurance	Preauthorization is required for partial hospital and intensive outpatient care. 25% coinsurance for partial hospital and intensive outpatient.
	Inpatient services	25% coinsurance	40% coinsurance	Preauthorization is required
If you are pregnant	Office visits	25% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	40% coinsurance	
If you need help recovering or have other special health	Home health care	25% coinsurance	40% coinsurance	Combined network and out-of-network: 100 visits per benefit period. Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
needs	Rehabilitation services	25% coinsurance	40% coinsurance	----------none----------
	Habilitation services	Not covered	Not covered	No coverage for habilitation services.
	Skilled nursing care	25% coinsurance	40% coinsurance	Combined network and out-of-network: 120 days per confinement. Preauthorization is required.
	Durable medical equipment	25% coinsurance	40% coinsurance	Preauthorization is required for some equipment.
	Hospice services	25% coinsurance	40% coinsurance	Preauthorization is required for inpatient care.
If your child needs dental or eye care	Children's eye exam	$15 copay /visit, deductible waived	Not covered	One routine eye exam every 12 months.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-term Care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.Other coverage options

* For more information about limitations and exceptions, see the plan or policy document at www.highmarkbcbsde.com.

may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-633-2563.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-633-2563.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-800-633-2563.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-633-2563.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

n The plan's overall deductible	$500
n Specialist copay	$25
n Hospital (facility) coinsurance	25%
n Other coinsurance	25%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,731

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

n The plan's overall deductible	$500
n Specialist copay	$25
n Hospital (facility) coinsurance	25%
n Other coinsurance	25%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$870
Coinsurance	$465
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,891

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

n The plan's overall deductible	$500
n Specialist copay	$25
n Hospital (facility) coinsurance	25%
n Other coinsurance	25%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$225
Coinsurance	$219
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$944

The plan would be responsible for the other costs of these EXAMPLE covered services.