Summary of Benefits and Coverage

In this booklet, you will find the Summary of Benefits and Coverage Document for the 2017 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.

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.highmarkbcbsde.com or by calling 1-800-633-2563.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500 individual/$1,000 family, network; $1,000 individual/$2,000 family, out-of-network. Network deductible does not apply to preventive care, routine eye exam, or services with copayments. Copayments, coinsurance amounts don't count toward the network 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 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?	No.	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. In-Network: $2,000 Individual/$3,500 Family; Out-of-Network $4,000 individual/$6,000 family for medical expenses; $3,000 Individual / $4,500 Family for prescription drug expenses	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?	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 network providers, see www.highmarkbcbsde.com or call 1-800-633-2563.	If you use a network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use an out-of-network provider for some services. Plans use the term network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	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 in the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about excluded services.

- 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 network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost if You Use a Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	40% coinsurance	----------none----------
	Specialist visit	$25 copay/visit	40% coinsurance	----------none----------
	Other practitioner office visit	$25 copay/visit for chiropractor	40% coinsurance for chiropractor	Coverage is limited to 30 visits per calendar year for Chiropractic Care.
	Preventive care Screening Immunization	No charge for preventive care services	40% coinsurance for preventive care services	Coverage is limited by age, gender and risk parameters as identified in Highmark Delaware's Preventive Health Care Guidelines.

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	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	Retail: $30 Copay Mail Order: $60 Copay		
	Non-Preferred Brand drugs	Retail: $50 Copay Mail Order: $100 Copay		
	Specialty drugs	$50 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 800-803-2523.
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 services	$100 copay/visit	$100 copay/visit	Copay waived if admitted as an inpatient. Applicable coinsurance and copays apply when additional services are rendered.
	Emergency medical transportation	$50 copay per occurrence	$50 copay per occurrence	––––––––––none––––––––––
	Urgent care	$35 copay/visit	$35 copay/visit	––––––––––none––––––––––
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fee	25% coinsurance	40% coinsurance	Preauthorization is required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay/visit	40% coinsurance	Preauthorization is required for partial hospital and intensive outpatient care.
	Mental/Behavioral health inpatient services	25% coinsurance	40% coinsurance	Preauthorization is required.
	Substance use disorder outpatient services	$15 copay/visit	40% coinsurance	Preauthorization is required for partial hospital and intensive outpatient care.
	Substance use disorder inpatient services	25% coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Prenatal and postnatal care	25% coinsurance	40% coinsurance	Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information.
	Delivery and all inpatient services	25% coinsurance	40% coinsurance	––––––––––none––––––––––
If you need help recovering or have other special health needs	Home health care	25% coinsurance	40% coinsurance	Combined network and out-of-network: 100 visits per benefit period. Preauthorization is required.
	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 benefit period. Preauthorization is required.
	Durable medical equipment	25% coinsurance	40% coinsurance	Preauthorization is required for some equipment.

	Hospice service	25% coinsurance	40% coinsurance	Preauthorization is required for inpatient care.
If your child needs dental or eye care	Eye exam	$15 copay/visit	Not covered	One routine eye exam every 12 months.
	Glasses	Not covered	Not covered	No coverage for glasses.
	Dental check-up	Not covered	Not covered	No coverage 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.)

- Acupuncture
- Care by Family Members
- Cosmetic surgery
- Custodial Care/Rest Homes
- Dental care (Adult)
- Experimental/Investigational Care
- Glasses
- Habilitation Services
- Hearing aids
- Long-term care
- Routine foot care
- Weight loss programs
- Worker's Compensation Claims

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.)

- Bariatric surgery
- Chiropractic care
- Allergy Testing and Treatment
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)

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 insurer at 1-800-633-2563. You may also contact your state insurance department at The Delaware Department of Insurance /Consumer Assistance Program at 302.674.7300 (local) or 800.282.8611 (toll free).

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:

- Highmark Blue Cross Blue Shield Delaware: 1-800-633-2563, or www.highmarkbcbsde.com.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- The Delaware Department of Insurance /Consumer Assistance Program: 841 Silver Lake Blvd, Dover, DE 19904, or 302.674.7300 (local), 800.282.8611 (toll free), or consumer@state.de.us.
- Additionally, the Delaware Department of Insurance/Consumer Assistance Program can help you file your appeal.

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

To obtain language assistance, call 1-800-633-2563.

- 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 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** $5,240
- **Patient pays** $2,300

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	$500
Copays	$0
Coinsurance	$1,600
Limits or exclusions	$200
Total	**$2,300**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $1,600
- **Patient pays** $3,800

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	$500
Copays	$100
Coinsurance	$300
Limits or exclusions	$2,900
Total	**$3,800**

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 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.