



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.highmarkbcbswv.com or by calling 1-888-601-2109.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible? | <p>\$4,000 individual/\$8,000 family network, \$8,000 individual/\$16,000 family out-of-network.</p> <p>Network deductible does not apply to preventive care services, pediatric dental exams and pediatric vision exams.</p> <p>Coinurance amounts don't count toward the network deductible.</p> | 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 3 for how much you pay for covered services after you meet the deductible . |
| Are there other deductibles for specific services? | Yes, Prescription Drugs \$250 per benefit period, per person. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| Is there an out-of-pocket limit on my expenses? | Yes, \$6,850 individual/ \$13,700 family network, \$13,700 individual/ \$27,400 family out-of-network. | 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 . |

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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.dol.gov/ebsa/healthreform and www.HealthCare.gov or call 1-888-601-2109 to request a copy.

A copy of your certificate book can be found at <https://shop.highmark.com/sales/#!/sbc-agreements>.

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Highmark West Virginia: Comprehensive Care Blue PPO 4000

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

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

Coverage for: Individual/Family | Plan Type: PPO

| | | |
|---|--|--|
| Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 3 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 network providers , see www.highmarkbcbswv.com or call 1-888-601-2109. | 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 in-network, preferred or participating for providers in their network . See the chart starting on page 3 for how this plan pays different kinds of providers . |
| Do I need a referral to see a <u>specialist</u> ? | 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 <u>excluded services</u> . |



- **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.

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Highmark West Virginia: Comprehensive Care Blue PPO 4000

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

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

Coverage for: Individual/Family | Plan Type: PPO

| 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 | \$70 copay/visit | 50% coinsurance | -----none----- |
| | Specialist visit | \$100 copay/visit | 50% coinsurance | -----none----- |
| | Other practitioner office visit | 50% coinsurance for chiropractor | 50% coinsurance for chiropractor | Combined network and out-of-network limit: 30 visits per benefit period. Combined network and out-of-network: Habilitation and rehabilitation services. |
| | Preventive care Screening Immunization | No charge for preventive care services | No coverage for preventive care services | Please refer to your preventive schedule for additional information. |
| If you have a test | Diagnostic test (x-ray, blood work) | Lab: \$70 copay X-Ray: 50% coinsurance | 50% coinsurance | -----none----- |
| | Imaging (CT/PET scans, MRIs) | 50% coinsurance | 50% coinsurance | -----none----- |

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Highmark West Virginia: Comprehensive Care Blue PPO 4000

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

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

Coverage for: Individual/Family | Plan Type: PPO

| 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 need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at 1-888-601-2109. | Generic drugs | 50% coinsurance (retail) 50% coinsurance (mail order) | Not covered | Up to 34-day supply retail pharmacy. Up to 90-day supply maintenance prescription drugs through mail order. This plan uses a Comprehensive Formulary. |
| | Brand drugs | 50% coinsurance (retail) 50% coinsurance (mail order) | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 50% coinsurance | 50% coinsurance | -----none----- |
| | Physician/surgeon fees | 50% coinsurance | 50% coinsurance | -----none----- |
| If you need immediate medical attention | Emergency room services | 50% coinsurance | 50% coinsurance | -----none----- |
| | Emergency medical transportation | 50% coinsurance | 50% coinsurance | -----none----- |
| | Urgent care | \$100 copay/visit | 50% coinsurance | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 50% coinsurance | 50% coinsurance | Precertification may be required. |
| | Physician/surgeon fee | 50% coinsurance | 50% coinsurance | -----none----- |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$70 copay/visit | 50% coinsurance | -----none----- |
| | Mental/Behavioral health inpatient services | 50% coinsurance | 50% coinsurance | Precertification may be required. |
| | Substance use disorder outpatient services | \$70 copay/visit | 50% coinsurance | -----none----- |
| | Substance use disorder inpatient services | 50% coinsurance | 50% coinsurance | Precertification may be required. |

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Highmark West Virginia: Comprehensive Care Blue PPO 4000

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

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

Coverage for: Individual/Family | Plan Type: PPO

| 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 are pregnant | Prenatal and postnatal care | 50% coinsurance | 50% 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 | 50% coinsurance | 50% coinsurance | Precertification may be required. |
| If you need help recovering or have other special health needs | Home health care | 50% coinsurance | 50% coinsurance | Combined network and out-of-network: 100 visits per benefit period. |
| | Rehabilitation services | 50% coinsurance | 50% coinsurance | Combined network and out-of-network limit: 30 visits each of occupational therapy and physical therapy per benefit period. |
| | Habilitation services | 50% coinsurance | 50% coinsurance | |
| | Skilled nursing care | 50% coinsurance | 50% coinsurance | Precertification may be required. |
| | Durable medical equipment | 50% coinsurance | 50% coinsurance | -----none----- |
| | Hospice service | 50% coinsurance | 50% coinsurance | -----none----- |
| If your child needs dental or eye care | Eye exam | No charge | Not covered | Maximum one exam per 12 month period. |
| | Glasses | No charge | Not covered | Maximum one pair of eyeglass lenses (including frames) per 12 month period. |
| | Dental check-up | No charge | Not covered | Maximum two exams per 12 month period. |

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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
- Cosmetic Surgery
- Dental Care
- Hearing aids
- Long-term care
- 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.)

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See www.bcbsa.com
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)

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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 1-888-601-2109.

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:

- A consumer assistance program can help you file your appeal. Contact: West Virginia Offices of the Insurance Commissioner, Consumer Service Division 1124 Smith St, Room 309 Charleston, WV 25301 **(888) 879-9842** <http://www.wvinsurance.gov>

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 obtain language assistance, call 1-888-601-2109.

SPANISH (Español): Para obtener asistencia en Español, llame al **1-888-601-2109**.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-601-2109**.

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码**1-888-601-2109**.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1-888-601-2109**.

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

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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.

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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Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays:** \$1,840
- **Patient pays:** \$5,700

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 | \$4,100 |
| Copays | \$0 |
| Coinsurance | \$1,600 |
| Limits or exclusions | \$0 |
| Total | \$5,700 |

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

- **Amount owed to providers:** \$5,400
- **Plan pays:** \$1,400
- **Patient pays:** \$4,000

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 | \$2,700 |
| Copays | \$0 |
| Coinsurance | \$1,300 |
| Limits or exclusions | \$0 |
| Total | \$4,000 |

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.

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