Independence

St. Joseph's University

Coverage Period: Beginning on or after 11/01/2014

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

Coverage for: FAMILY | **PlanType:** HMO

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.ibx.com or by calling 1-800-ASK-BLUE.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your other costs for services this plan covers.
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?	$1,500 person / $3,000 family	The out-of-pocket limit is the most you could pay during a policy period 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 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. See www.ibx.com/find_a_provider or call 1-800-ASK-BLUE for a list of participating providers.	If you use an in-network doctor or other health care provider, 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 provider for some services. Plans use the term in-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?	Yes. Electronic referral required.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.
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 participating providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		a Referred Provider	an Out Of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment	Not Covered	----------none----------
	Specialist visit	$35 copayment	Not Covered	PCP referral required.
	Other practitioner office visit	No Charge	Not Covered	Spinal Manipulations covered up to 60 consecutive visits per benefit period subject to significant improvement. PCP referral required.
	Preventive care / screening / immunization	No Charge	Not Covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	PCP referral required for x-rays. Requisition form required for lab work.
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	Precertification required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.ibx.com/preapproval	Generic drugs	$20 Copayment (Retail)/ $20 Copayment (1-30 days supply)(Mail Order); $40 Copayment (31-90 days supply)(Mail Order)	70%	Prior authorization required on some drugs; age, gender and quantity limits for some drugs; days supply limits on retail & mail order.

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		a Referred Provider	an Out Of Network Provider	
	Preferred brand drugs	$40 Copayment (Retail)/ $40 Copayment (1-30 days supply)(Mail Order); $80 Copayment (31-90 days supply)(Mail Order)	70%	Prior authorization required on some drugs; age, gender and quantity limits for some drugs; days supply limits on retail & mail order.
	Non-preferred brand drugs	$60 Copayment (Retail)/ $60 Copayment (1-30 days supply)(Mail Order); $120 Copayment (31-90 days supply)(Mail Order)	70%	Prior authorization required on some drugs; age, gender and quantity limits for some drugs; days supply limits on retail & mail order.
	Specialty drugs	No Charge	Not Covered	Prior-authorization required. A complete list of drugs requiring prior-authorization is available at www.ibx.com/preapproval
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 Copayment	Not Covered	Some outpatient surgeries require precertification. A complete list of surgeries requiring precertification is available at www.ibx.com/preapproval
	Physician/surgeon fees	No Charge	Not Covered	Some outpatient surgeries require precertification. A complete list of surgeries requiring precertification is available at www.ibx.com/preapproval
If you need immediate medical attention	Emergency room services	Covered with a $150 copayment	Covered with a $150 copayment	Your costs for Emergency Room services are waived if you are admitted to the hospital.
	Emergency medical transportation	Covered No Charge when medically necessary	Covered No Charge when medically necessary	----------none----------
	Urgent care	$105 Copayment	Not Covered	Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physician's office. Costs may vary depending on where you receive care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 Copayment/ admission	Not Covered	Precertification required.
	Physician/surgeon fee	No Charge	Not Covered	Precertification required.
If you have mental health, behavioral	Mental/Behavioral health outpatient services	$35 Copayment	Not Covered	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		a Referred Provider	an Out Of Network Provider	
health, or substance abuse needs	Mental/Behavioral health inpatient services	$100 Copayment	Not Covered	Precertification required.
	Substance abuse disorder outpatient services	$35 Copayment	Not Covered	Precertification required.
	Substance abuse disorder inpatient services	$100 Copayment	Not Covered	Precertification required.
If you are pregnant	Prenatal and postnatal care	Covered with a $35 copayment for the first visit. Subsequent visits to your OB/GYN covered No Charge. Inpatient care covered with a $100 copayment per admission	Not Covered	Your cost is for first OB visit only.
	Delivery and all inpatient services	No Charge	Not Covered	Pre-notification requested
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Precertification required.
	Rehabilitation services	No Charge	Not Covered	Speech/Physical/Occupational: Up to 60 consecutive days per condition covered, subject to significant improvement. PCP referral required.
	Habilitation services	No Charge	Not Covered	Speech/Physical/Occupational: Up to 60 consecutive days per condition covered, subject to significant improvement. PCP referral required.
	Skilled nursing care	No Charge	Not Covered	Precertification required.Up to 180 days per calendar year.
	Durable medical equipment	All purchases and rentals (including repairs and replacements) are covered No Charge	Not Covered	Precertification required for purchases (including repairs and replacements) over $500 and all rentals
	Hospice service	No Charge	Not Covered	----------none----------
If your child needs dental or eye care	Eye exam	$35 copayment	Not Covered	Once every two calendar years.
	Glasses	Covered 100% on all Davis Collection of frames	Up to $100 reimbursement to member	Once every two calendar years

Common Medical Event	Services You May Need	Your Cost If You Use		Limitations & Exceptions
		a Referred Provider	an Out Of Network Provider	
	Dental check-up	Not Covered	Not Covered	----------none----------

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
- Hearing aids
- Non-emergency care when traveling outside the U.S. (For details, see www.ibx.com)
- Cosmetic surgery
- Infertility treatment
- Routine foot care
- Dental care (Adult)
- Long-term 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
- Routine eye care (Adult)
- Chiropractic care
- Private-duty nursing

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 plan at 1-888-671-5276.You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

Your health plan is subject to Employee Retirement Income Security Act (ERISA) requirements. If you are dissatisfied with a denial of coverage for claims under your plan, you may contact IBC at 1-800-ASK-BLUE. You may also contact the U.S. Dept. of Labor Employee Benefits Security Administration at 1-866-444-3272. As an alternative, the Pennsylvania Department of Insurance can also provide assistance. Please contact them 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.

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** $7,370
- **Patient Pays** $170

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	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	$170

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

- **Amount owed to providers:** $5,400
- **Plan Pays** $3,570
- **Patient Pays** $1,830

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	$0
Copays	$1,750
Coinsurance	$0
Limits or exclusions	$80
Total	$1,830

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 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.