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

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible? | For participating providers $1,500 person / $3,000 family. For non-participating providers $5,000 person / $10,000 family. Deductible may not apply to all services. See your cost information starting on page 2 for specific details. | 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. For participating providers $5,600 person / $11,200 family. For non-participating providers $10,000 person / $20,000 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, out-of-network deductibles, out-of-network balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain precertification for 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 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. |

Questions: Call 1-800-ASK-BLUE or visit us at www.ibx.com.

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.ibx.com or call 1-800-ASK-BLUE to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| 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 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 |
|---|---|---|---|---|
| | | an In-Network 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 | No Charge after deductible | 50%, after deductible | ----------none---------- |
| | Specialist visit | No Charge after deductible | 50%, after deductible | ----------none---------- |
| | Other practitioner office visit | No Charge after deductible | 50%, after deductible | Spinal manipulations limited to 20 visits per benefit period combined in and out-of-network. |
| | Preventive care / screening / immunization | No Charge | 50%, no deductible | Age and frequency schedules may apply. |
| If you have a test | Diagnostic test (x-ray, blood work) | No Charge after deductible | 50%, after deductible | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | No Charge after deductible | 50%, after deductible | Precertification required. |
| If you need drugs to treat your illness or | Generic drugs | $5 Copayment, after deductible(Retail)/ | 50%, after deductible | Prior authorization required on some drugs; age, gender and quantity limits for some drugs; days |

| Common Medical Event | Services You May Need | Your Cost If You Use | | Limitations & Exceptions |
|---|---|---|---|---|
| | | an In-Network Provider | an Out-Of Network Provider | |
| condition<br><br>More information about prescription drug coverage is available at http://www.ibx.com/preapproval | | $10 Copayment, after deductible(Mail Order) | | supply limits on retail & mail order. |
| | Preferred brand drugs | $20 Copayment, after deductible(Retail)/ $40 Copayment, after deductible(Mail Order) | 50%, after deductible | 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 | $45 Copayment, after deductible(Retail)/ $90 Copayment, after deductible(Mail Order) | 50%, after deductible | Prior authorization required on some drugs; age, gender and quantity level limits for some drugs; days supply limits on retail & mail order. |
| | Specialty drugs | No Charge after deductible | 50%, after deductible | 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) | No Charge after deductible | 50%, after deductible | Some outpatient surgeries require precertification. A complete list of surgeries requiring precertification is available at www.ibx.com/preapproval |
| | Physician/surgeon fees | No Charge after deductible | 50%, after deductible | 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 | No Charge after deductible | No Charge after in-network deductible | Your costs for Emergency Room services are not waived if you are admitted to the hospital. |
| | Emergency medical transportation | No Charge after deductible | No Charge after in-network deductible | ----------none---------- |
| | Urgent care | No Charge after deductible | 50%, after deductible | 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) | No Charge after deductible | 50%, after deductible | Precertification required. |
| | Physician/surgeon fee | No Charge after deductible | 50%, after deductible | Precertification required. |
| If you have mental health, behavioral health, or substance | Mental/Behavioral health outpatient services | No Charge after deductible | 50%, after deductible | ----------none---------- |

| Common Medical Event | Services You May Need | Your Cost If You Use | | Limitations & Exceptions |
|---|---|---|---|---|
| | | an In-Network Provider | an Out-Of Network Provider | |
| abuse needs | Mental/Behavioral health inpatient services | No Charge after deductible | 50%, after deductible | Precertification required. |
| | Substance abuse disorder outpatient services | No Charge after deductible | 50%, after deductible | Precertification required. |
| | Substance abuse disorder inpatient services | No Charge after deductible | 50%, after deductible | Precertification required. |
| If you are pregnant | Prenatal and postnatal care | No Charge after deductible | 50%, after deductible | Your cost is for first OB visit only. |
| | Delivery and all inpatient services | No Charge after deductible | 50%, after deductible | Pre-notification requested |
| If you need help recovering or have other special health needs | Home health care | No Charge after deductible | 50%, after deductible | Precertification required. |
| | Rehabilitation services | No Charge after deductible | 50%, after deductible | Speech Therapy: 20 visits per benefit period; Physical/Occupational Therapies: 30 visits combined per benefit period. All visit limits combined in- and out-of-network. |
| | Habilitation services | No Charge after deductible | 50%, after deductible | Speech Therapy: 20 visits per benefit period; Physical/Occupational Therapies: 30 visits combined per benefit period. All visit limits combined in- and out-of-network. |
| | Skilled nursing care | No Charge after deductible | 50%, after deductible | 120 day limit per benefit period combined in and out-of-network. Precertification required |
| | Durable medical equipment | No Charge after deductible | 50%, after deductible | Precertification required for purchases (including repairs and replacements) over $500 and all rentals |
| | Hospice service | No Charge after deductible | 50%, after deductible | ----------none---------- |
| If your child needs dental or eye care | Eye exam | Not Covered | Not Covered | ----------none---------- |
| | Glasses | Not Covered | Not Covered | ----------none---------- |
| | 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 | • Cosmetic surgery | • Dental care (Adult) |
| • Hearing aids | • Infertility treatment | • Long-term care |
| • Routine eye care (Adult) | • 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 | • Non-emergency care when traveling outside the U.S. (For details, see www.ibx.com) |
| • 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** $5,880
- **Patient Pays** $1,660

**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 | $10 |
| Coinsurance | $0 |
| Limits or exclusions | $150 |
| Total | $1,660 |

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

- **Amount owed to providers:** $5,400
- **Plan Pays** $2,930
- **Patient Pays** $2,470

**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 | $1,500 |
| Copays | $890 |
| Coinsurance | $0 |
| Limits or exclusions | $80 |
| Total | $2,470 |

# 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.