Devereux – Blue Cross Tier 2

Coverage Period: 01/01/2012 – 12/31/2021

Summary of Benefits and Coverage: What this Plan Covers & What it Costs
Coverage for: Individual/Employee + Child/Employee + Spouse/Family
Plan Type: Closed Panel 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 for medical and prescription drug coverage at **www.ibx.com** **or by calling 1-800-ASK-Blue**. For Behavioral Health/Substance Abuse questions visit **MagellanAscend.com** or call 1-800-220-1570.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For participating providers $475 individual/$715 EE+ Child/$950 EE + Spouse or family. Deductible may not apply to all services. See your cost information 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 your meet the **deductible.**
Are there other deductibles for specific services?	Yes, Bariatric Surgery has a 50% Deductible and no Out of Pocket Maximum.	Yes, you have a different deductible for Bariatric Surgery.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers $2,750 Individual/$4,160EE + Child/$5,550 EE + Spouse or family. Bariatric has no OOP.	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 charges, health care this plan doesn't cover, Bariatric Surgery 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**.

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 on page 4. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 provides no out of network coverage unless it is for emergency services.

Common Medical Event	Services You May Need	Your cost if you use an In-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 visits to treat an injury or illness	$20 Copayment, No Deductible	Not Covered	--------none--------
	MD LIVE Telemedicine	$10 Copayment, No Deductible	Not Covered	--------none--------
	Specialist visit	$50 Copayment, No Deductible	Not Covered	--------none--------
	Other practitioner office visit	$40 Copayment	Not Covered	--------none--------
	Preventive care/screening/immunization	$0 Copayment, no Deductible	Not Covered	Call Health Advocate at 866-695-8622 for a schedule of benefits.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% after deductible (X-Ray)/ No Charge, No Deductible (Blood Work)	Not Covered	There is no cost for diagnostic services received in the Emergency Room or during a doctor's office visit.
	Imaging (MRI/CT Scans) PET Scans	$100 Copayment; 20% Coinsurance $100 Copayment No Deductible; no coinsurance	Not Covered	Precertification required. There is no cost for diagnostic services received in the Emergency Room or during a doctor's office visit.
If you need drugs to treat your illness or condition Prescription Drugs are available through Independence Blue Cross – FutureScripts Only. You can order prescriptions by visiting www.ibx.com or get more information by calling 1-888-678-7012.	**Generic drugs**: Original Prescription and One Refill at Retail; additional fills through Mail Order Only. Generic Step Therapy Applies. Must use Generic drug first if available.	15% ($5 Minimum)	-------none------	Contraceptives – Generic and Single Source Brands until Generic is available covered at 100% Maximum Out of Pocket Expense $3,600 Single, $5,400 EE/Child and $7,200 EE/Spouse or Family coverage.
	Preferred brand drugs Original Prescription and One Refill at Retail; additional fills through Mail Order Only. Generic Step Therapy Applies. Must use Generic drug first if available.	35% ($10 Minimum)	-------none------	Contraceptives – Generic and Single Source Brands until Generic is available covered at 100% Maximum Out of Pocket Expense $3,600 Single, $5,400 EE/Child and $7,200 EE/Spouse or Family coverage.
	Non-preferred brand drugs Original Prescription and One Refill at Retail; additional fills through Mail Order Only. Generic Step Therapy Applies. Must use Generic drug first if available.	50% (No Minimum)	-------none------	Contraceptives – Generic and Single Source Brands until Generic is available covered at 100% Maximum Out of Pocket Expense $3,600 Single, $5,400 EE/Child and $7,200 EE/Spouse or Family coverage.

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Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
	Specialty Drugs – Through BriovaRx Only. Dispensed in 30-day supply. Specialty Step Therapy applies.	35%	Not Covered	Maximum Out of Pocket Expense $3,600 Single, $5,400 EE/Child and $7,200 EE/Spouse or Family coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	Not Covered	Some outpatient surgeries require precertification. A complete list of surgeries requiring precertification in available www.ibx.com/preapproval.
	Physician/surgeon fees	20% after deductible	Not Covered	Some outpatient surgeries require precertification. A complete list of surgeries requiring precertification in available www.ibx.com/preapproval.
If you need immediate medical attention	Emergency room services	$275 Copayment; No Deductible	$275 Copayment; No Deductible	Your cost for Emergency Room services is waived if you are admitted into the hospital.
	Emergency medical transportation	20% after deductible	Not covered	Precertification is required for all non-emergency services.
	Urgent care	$50 Copayment	Not Covered	
	Minute Clinic/Take Care Clinic MD LIVE (Telemedicine)	$20 Copayment $10 Copayment	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 Co-pay; then 20% after Deductible	Not Covered	If your plan includes a copay for these services, your copay will be waived if you are readmitted to the hospital within 10 days of discharge. If your plan covers these services with coinsurance, your costs will not be waived if you are readmitted.
	Physician/surgeon fee	20% after Deductible	Not Covered	Precertification required

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
Behavior Health and Substance Abuse Benefits are provided through Magellan Health Services. If you have mental health, behavioral health, or substance abuse needs, call Magellan at 1-800-220-1570 or MagellanAscend.com **EAP services offered through Carebridge by calling 1-800-437-0911 or www.myliferesource.com** **Access Code ADC53**	Mental/Behavioral Health/Substance Abuse outpatient services including Individual, Group, Family routine psychotherapy, medication management office visits.	$20/visit Unlimited visits;	50% of usual, customary and reasonable charges. Limited to 20 visits per year/120 lifetime visits; medical deductible and copay apply	No prior authorization on outpatient benefits. Claim forms for Out of Network providers are available by calling 1-800-220-1570.
	Mental/Behavioral Health/Substance Abuse inpatient services including, acute inpatient care, residential, supervised living, partial hospitalization and intensive outpatient programs.	0% co-pay; medical deductible and copay apply	50% of usual, customary and reasonable charges to a maximum of 125% of in-network rate. Limited to 30 days per year/90 lifetime days; medical deductible and copay apply	Prior authorization applies in and out of network; 1-800-220-1570.
	Certain outpatient care requires prior authorization including, Intensive Outpatient Program, electroconvulsive treatment, psychological testing, hypnotherapy, biofeedback, treatment not consistent with usual practices.	Medical deductible and copay apply		Prior authorization applies in and out of network; 1-800-220-1570.
If you are pregnant	Prenatal and postnatal care	$20 Copayment, No Deductible	Not Covered	Your cost is for first OB visit only.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
	Delivery and all inpatient services	$250 Copayment after deductible, then 20%.	Not Covered	Pre-notification requested.
If you need help recovering or have other special health needs	Home health care	20% after deductible	Not Covered	Precertification required.
	Rehabilitation services	$40 Copayment; No Deductible	Not Covered	Speech, Physical & Occupational Therapy; 60 visits per benefit period; Precertification required for speech therapy.
	Habilitation services	$40 copayment; No Deductible	Not Covered	Speech, Physical & Occupational Therapy; 60 visits per benefit period; Precertification required for speech therapy
	Skilled nursing care	20% after deductible	Not Covered	120-day limit per benefit period. Precertification required.
	Durable medical equipment	0% after deductible	Not Covered	Precertification required for purchases (including repairs and replacements) over $500 and all rentals.
	Hospice service	20% after deductible	Not Covered	Precertification required.
If you or dependent child needs dental or eye care	Eye exam	Davis Vision $0 copay	Not Covered	Benefit Frequency 1x per calendar year
	Glasses	Davis Vision $0-$25 copay or $130 toward selection	Not Covered	Benefit Frequency 1x per calendar year
	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.)		
• Weight Loss Programs (Bariatric Surgery covered at 50%; no OOP Maximum)	• Cosmetic Surgery • Infertility Treatment • Routine Foot Care	• Dental Care • Long-term Care • Hearing Aids

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 (covered at 50%; no OOP Maximum) • Private Duty Nursing	• Chiropractic Care • Most Coverage provided outside the United States. See www.ibx.com	• Non-emergency care when travelling outside the United States.

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:
If your health plan is subject to Employee Retirement Income Security Act (ERISA) requirements, you may contact the U.S. Dept. of Labor Employee Benefits Security Administration at 866-444-3272, and following an appeal, you may have the right to bring a civil suit under Section 502(a) of the Act.

Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Minimum Essential Coverage
Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-ASK-BLUE

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-ASK-BLUE

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-ASK-BLUE

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-ASK-BLUE

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

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

- The plan's overall deductible $475
- Specialist copayment $50
- Hospital (facility) *[cost sharing]* 20%
- Other *[hospital copay cost sharing]* $250

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education); *Specialist Office Visits
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	$475
Copayments	$300
Coinsurance	$1,325
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,100**

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

- The plan's overall deductible $475
- Specialist copayment $50
- Hospital *[cost sharing]* 20%
- Other *[hospital copay cost sharing]* $250

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$475
Copayments	$300
Coinsurance	$225
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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

- The plan's overall deductible $475
- Specialist *[cost sharing]* $50
- Hospital (facility) *[cost sharing]* 20%
- Other *[hospital copay cost sharing]* $250

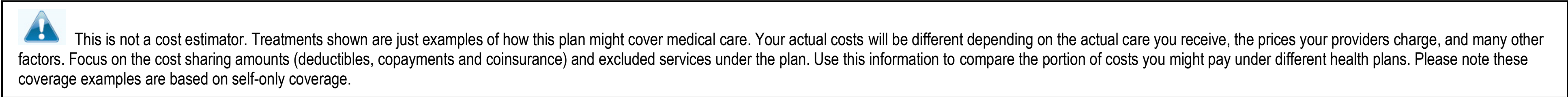
This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$475
Copayments	$300
Coinsurance	$1,975
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,750**

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


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.

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**, **co-payments**, and **co-insurance** 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.