2016 Horizon Blue Cross Blue Shield Medical Summary Sheet

Summary of Benefits	*Horizon Blue Cross Blue Shield BlueCard PPO Plan*		*Horizon Blue Cross Blue Shield MyWay H.S.A. Medical Plan (utilizing the BlueCard PPO network)*	
Benefit	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	(Most Services less than 100% paid are Subject to Deductibles) (Any maximums combine in-network and out-of-network services.)		(Most Services less than 100% paid are Subject to Deductibles) (Any maximums combine in-network and out-of-network services.)	
Individual	$500		$1,500 - applies to Employee Only coverage	
Family	$1,000		$3,000 - must be met by the sum of all members covered (family aggregate)	
Annual Out-of-Pocket Maximum				
Individual	$4,000 including all deductibles and copays	$5,000 including all deductibles	$4,000 including deductible	$5,000 including deductible
Family	$8,000 including all deductibles and copays	$10,000 including all deductibles	$8,000 including deductible	$10,000 including deductible
Lifetime Maximum	Unlimited		Unlimited	
Office Visit				
PCP (Family Practice, Internal Medicine, General Practice, OB/GYN and Pediatrician)	100% after $20 copay per visit	60% after deductible	80% after deductible	60% after deductible
Specialist	100% after $40 copay per visit	60% after deductible	80% after deductible	60% after deductible
Routine Preventive Care *[Based on frequency guidelines contact Horizon for details]*				
Routine Preventive Care for Children including immunizations up to age 19	100% (no deductible)	Not Covered	100% (no deductible)	Not Covered
Routine Preventive Physical Exams for Adults Annually	100% (no deductible)	Not Covered	100% (no deductible)	Not Covered
Well Woman Care including Pap Test Annually	100% (no deductible)	Not Covered	100% (no deductible)	Not Covered
Colonoscopy	100% (no deductible)	Not Covered	100% (no deductible)	Not Covered
Mammograms	100% (no deductible)	Not Covered	100% (no deductible)	Not Covered
Prostate Cancer Screenings	100% (no deductible)	Not Covered	100% (no deductible)	Not Covered
X-Ray and Lab (non routine)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Prescription Drugs - provided through Express Scripts **	Participating Pharmacy		Participating Pharmacy	
Retail Generic	100% after $10 per 30 day supply from EAN/$15 copay if not a preferred pharmacy and $50 ind. / $100 family annual drug deductible		80% after the annual medical deductible listed above	60% after the annual medical deductible listed above
Retail Preferred Brand	100% after $25 per 30 day supply from EAN/$30 copay if not a preferred pharmacy and $50 ind. / $100 family annual drug deductible		80% after the annual medical deductible listed above	60% after the annual medical deductible listed above
Retail Non-Preferred Brand	100% after $50 per 30 day supply from EAN/$55 copay if not a preferred pharmacy and $50 ind./$100 family annual drug deductible		80% after the annual medical deductible listed above	60% after the annual medical deductible listed above
DAW & coverage management rules apply (see last page)	***EAN = Express Advantage Network		Note - some preventive drugs do not require the deductible to be met first.	
(Note - There are a few preventive drugs that are paid at 100% - contact Express Scripts for details.)	Non-participating Pharmacy: The plan will reimburse only the amount it would have paid a participating pharmacy, less the applicable deductible and copayment.		Deductible and Out-of Pocket maximum apply. Non-participating Pharmacy: The plan will reimburse only the amount it would have paid a participating pharmacy, less the applicable deductible and coinsurance.	
Mail Order Generic	100% after $25 per 90 day supply*		80%** after deductible per 90 day supply	Not Covered
Mail Order Preferred Brand	100% after $62.50 per 90 day supply*		80%** after deductible per 90 day supply	Not Covered
Mail Order Non-Preferred Brand	100% after $125 per 90 day supply*		80%** after deductible per 90 day supply	Not Covered
DAW rules apply (see last page)				
(Must use Express Script's Mail Order Program)	**no annual drug deductible applies to mail order prescriptions*		*** the annual medical deductible also applies to mail order prescriptions*	
Emergency				
Emergency Room	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Non-Emergency Diagnosis	60% after deductible	60% after deductible	60% after deductible	60% after deductible
Ambulance only if Medically necessary	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Maternity				
Initial Visit to Confirm Pregnancy / Prenatal / Postnatal Visits	100% after copay	60% after deductible	80% after deductible	60% after deductible
Hospital	80% after deductible	60% after deductible	80% after deductible	60% after deductible

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Hospital Inpatient				
Preadmission Certification is Required	Patient must get approval	Patient must get approval	Patient must get approval	Patient must get approval
Facility Charges	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Doctors Visits	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Surgical Facility	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Surgery				
Surgeons Fees (In patient surgery must be approved)	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Second Opinion Consultation - Outpatient / Out of Hospital	100% after copay	60% after deductible	80% after deductible	60% after deductible
Infertility *(Testing, diagnosis and corrective procedures only)*				
Office Visit	100% after copay	60% after deductible	80% after deductible	60% after deductible
Surgery	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Rehabilitation *(provider)*	(Limits combined for in and out of network)	(Limits combined for in and out of network)	(Limits combined for in and out of network)	(Limits combined for in and out of network)
Includes Physical, Cognitive, Speech and Occupational Therapy	100% after copay up to 60 visits per year	60% after deductible up to 60 visits per year	80% after deductible up to 60 visits per year	60% after deductible up to 60 visits per year
Chiropractic Therapy (There may be a separate facility charge)	100% after copay up to 30 visits per year	60% after deductible up to 30 visits per year	80% after deductible up to 30 visits per year	60% after deductible up to 30 visits per year
Special Services	(Limits combined for in and out of network)	(Limits combined for in and out of network)	(Limits combined for in and out of network)	(Limits combined for in and out of network)
Skilled Nursing Facility	80% after deductible, up to 60 days per year	60% after deductible, up to 60 days per year	80% after deductible up to 60 days per year	60% after deductible up to 60 days per year
Home Health Care	80% after deductible, up to 40 visits per year	60% after deductible, up to 40 visits per year	80% after deductible up to 40 visits per year	60% after deductible up to 40 visits per year
Private Duty Nursing	80% after deductible, up to 30 days per year	60% after deductible, up to 30 days per year	80% after deductible up to 30 days per year	60% after deductible up to 30 days per year
Hospice - Inpatient and Outpatient	80% after deductible up to 180 days (Hospice in and outpatient limits combined)	60% after deductible up to 180 days (Hospice in and outpatient limits combined)	80% after deductible up to 180 days (Hospice in and outpatient limits combined)	60% after deductible up to 180 days (Hospice in and outpatient limits combined)
Other Services				
Nutritional Counseling (limited to 3 per year, in a providers office)	100% after $40 copay per visit	60% after deductible	80% after deductible	60% after deductible
Durable Medical Equipment	80% after deductible	60% after deductible	80% after deductible	60% after deductible
External Prosthetic Appliance	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Mental Health & Substance Abuse Rehabilitation				
Inpatient (Pre-certification with Horizon Behavioral Health is required)*	80% after deductible*	60% after deductible*	80% after deductible*	60% after deductible*
Outpatient - provider	100% after copay	60% after deductible	80% after deductible	60% after deductible
Group Therapy	Same as Mental Health & Substance Abuse	Same as Mental Health & Substance Abuse	Same as Mental Health & Substance Abuse	Same as Mental Health & Substance Abuse
Therapy Services (outpatient) Chemotherapy, radiation and dialysis				
Provider	100% (no deductible)	60% (no deductible)	80% after deductible	60% after deductible
Facility	100% (no deductible)	60% (no deductible)	80% after deductible	60% after deductible
Dental Services (outpatient) *(Oral tumors, cysts, bony impacted teeth, accidental injury, TMJ)*				
Provider	100% after copay	60% after deductible	80% after deductible	60% after deductible
Facility	80% after deductible	60% after deductible	80% after deductible	60% after deductible

All Coinsurance is Subject to Deductibles and a Plan Allowance (R&C) as determined by Horizon Blue Cross Blue Shield. **The Rx drug Copays & Deductibles also build towards the Annual Out-Of-Pocket Maximum.
Once the Out-of-Pocket Maximum is met, 100% of eligible charges are paid for the remainder of the plan year. In-Network PPO Office Visit copays apply towards the Out-Of-Pocket Maximums, as well as the deductible for all plans.
Prescription Drug DAW (Dispense As Written) rules apply - the cost difference between the brand and the generic will be charged when a brand medication is requested and a generic equivalent is available.
*****You pay a lower copay when a preferred pharmacy is used = EAN (Express Advantage Network). Certain prescription drug coverage management rules and programs are in effect. Contact Express Scripts at 1-877-861-0355 with any spec**

This Medical Benefit Summary is effective January 1, 2016. The Summary Plan Description and Insurance Contract will prevail if any discrepancies arise.
Suburban Propane reserves the right, at its discretion, to amend, change, or terminate any of its benefit plans, programs, practices, or policies. Contact Horizon Customer Service with any specific benefit coverage questions at 1-800-355-2583.