Harland Clarke Holdings Corp.:Exclusive Provider Plan

Coverage Period: 01/01//2013 to 12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee, Employee+Spouse, Employee+Child (ren), Family | **Plan Type: EPO**

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.bcbstx.com/harlandclarke or by calling (800)382-0818.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** Individual/**$3,000** Family Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for the covered services you use. Check your 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 **$3,000** Individual / **$6,000** Family	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?	Co-payments, Premiums, Balance-billed charges, 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?	**Yes. $2** million	The amount the Plan will pay for essential Benefits during the plan year.
Does this plan use a network of providers?	**Yes.** For a list of network providers see bcbstx.com/harlandclarke	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the cost of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. The Plan uses 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 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 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-(800)521-2227 or visit us at www.bcbstx.com/harlandclarke.
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.cciio.cms.gov or call the number above to request a copy.

- **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 only covers services if rendered by **in-network providers**. Exceptions include emergency services as described in your policy.

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 visit to treat an injury or illness	$30 copay/visit	Not Covered	----------none----------
	Specialist visit	$40 copay/visit	Not Covered	----------none----------
	Other practitioner office visit	$40 copay/visit for chiropractor and acupuncture	Not Covered	Acupuncture and Naturopathic Services (Copay is per visit) up to $1,000 per calendar year per covered person. Chiropractic 20 visit maximum per calendar year.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	For services from an independent Lab and X-ray provider
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	Prior Notification required for certain covered health 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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$15 copay/ prescription (retail)	Not Covered	Covers up to 30 day supply (retail); Mail order copays are 2 ½ times the retail amount for a 90 day supply. Mail order required on maintenance drugs at 3rd fill, otherwise penalties apply.
	Preferred brand drugs	$40 copay/ (retail)	Not Covered	
	Non-preferred brand drugs	$80 copay/ (retail)	Not Covered	
	Specialty drugs	Generic $37.50; Preferred Brand $100; Non-preferred Brand $200	Not Covered	Specialty drugs must go through specialty mail order. Specialty drugs are initially dispensed in 30 day supply (even if the doctor writes a prescription for 90 days) to ensure tolerance and avoid wastage. Mail order copays are 2 ½ times the retail amount for a 90 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	----------none----------
	Physician/surgeon fees	20% coinsurance	Not Covered	----------none----------
If you need immediate medical attention	Emergency room services	$125 copay/visit	$125 copay/visit	Non-emergency Care 20% coinsurance after $250 copay/visit.
	Emergency medical transportation	20% coinsurance	20% coinsurance	----------none----------
	Urgent care	$50 copay/visit	Not Covered	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	Prior Notification required for certain covered health services
	Physician/surgeon fee	20% coinsurance	Not Covered	

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 mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/visit	Not Covered	Prior Notification required for certain covered health services.
	Mental/Behavioral health inpatient services	20% coinsurance	Not Covered	
	Substance use disorder outpatient services	$30 copay/visit	Not Covered	
	Substance use disorder inpatient services	20% coinsurance	Not Covered	
If you are pregnant	Prenatal and postnatal care	$30 copay/visit	Not Covered	----------none----------
	Delivery and all inpatient services	20% coinsurance	Not Covered	Prior Notification required for certain covered health services.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	120 visits per calendar year. Prior Notification required for certain covered health services.
	Rehabilitation services	20% coinsurance	Not Covered	120 visits of physical, occupational, habilitation, and speech therapy combined. 30 visits of pulmonary rehab therapy. No visit limit for cardiac rehabilitation therapy. Visit maximums per calendar year.
	Habilitation services	20% coinsurance	Not Covered	
	Skilled nursing care	20% coinsurance	Not Covered	120 day per calendar year. Prior Notification required for certain covered health services.
	Durable medical equipment	20% coinsurance	Not Covered	----------none----------
	Hospice service	20% coinsurance	Not Covered	Prior Notification required for certain covered health services.
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Vision Screening only.

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.)		
• Cosmetic Surgery	• Long Term Care	• Weight Loss Programs
• Dental Care	• Private Duty Nursing	
• Glasses	• Routine Eye Care	
• Infertility Treatment	• Routine Foot Care	

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.)		
• Acupuncture/Naturopathic limited to $1,000/year	• Chiropractic Care limited to 20 visits/year	• Non-emergency care when traveling outside the U.S.
• Bariatric Surgery (additional $1,000 copay per admission)	• Hearing Aids (as a result of an accident only)	• Organ and Tissue Transplant

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 1-800- 382-0818. You may also contact 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 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:

BlueCross and Blue Shield of Texas at 1 800-382-0818 or www.bcbstx.com
Express-Scripts at 1-800-753-2851 or fax 1-888-235-8551 or www.express-scripts.com

www.texashealthoptions.com or you may also contact 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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al (800)-382-0818
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800)-382-0818
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** (800)-382-0818
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800)-382-0818

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** $5,135
- **Patient pays** $ 2,405

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	$1000
Copays (office & prescription)	$145
Coinsurance	$1,260
Limits or exclusions	$0
Total	**$2,405**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,320
- **Patient pays** $2,080

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	$1,000
Copays (office & prescription)	$760
Coinsurance	$320
Limits or exclusions	$0
Total	**$2,080**

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.