Administered by Capital BlueCross[1]

Base/Rx - Active

Coverage Period: 1/1/2015 - 12/31/2015

Summary of Benefits and Coverage: What this Plan[2] Covers & What it Costs

Coverage for: All **| Plan Type:** 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 **capbluecross.com** or by calling **1-800-962-2242**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500**/person/**$1,000**/family participating providers **$1,000**/person/**$2,000**/family non-participating providers. Deductible applies to **all** in-network services, including prescription drug, before any copayment or coinsurance are applied. Doesn't apply to professional services with co-pays, network preventive services, emergency services or emergency ambulance.	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, **$6,600**/person/**$13,200**/family/participating providers **$6,600**/person/**$13,200**/family/non-participating providers; combined out-of-pocket limit for in-network medical and prescription drug.	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?	Pre-authorization penalties, premium, balance-billed charges, 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. For a list of participating providers, see **capbluecross.com** or call 1-800-962-2242.	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 for 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 5. 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**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	20% coinsurance	----------none----------
	Specialist visit	$30 copay/visit	20% coinsurance	
	Other practitioner office visit	$30 copay/visit for chiropractic	20% coinsurance for chiropractic	Acupuncture not covered.
	Preventive care / screening / immunization	No charge	20% coinsurance	Deductible does not apply to services at participating providers.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for lab or tests.	20% coinsurance	----------none----------
	Imaging (CT / PET scans, MRIs)	No charge	20% coinsurance	Preauthorization is required.[3]

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If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at capbluecross.com	Generic drugs	25% coinsurance (retail prescription) $25 copay (mail order prescription)		Covers up to 30-day supply (retail prescription) 90-day supply (mail order prescription)
	Preferred brand drugs	25% coinsurance (retail prescription) $75 copay (mail order prescription)		
	Non-preferred brand drugs	45% coinsurance (retail prescription) $125 copay (mail order prescription)		
	Specialty drugs	25% coinsurance (generic) 25% coinsurance (preferred) 25% coinsurance (non-preferred)		Prescription written for up to 30 days supply. $150 maximum copay (generic) $150 maximum copay (preferred brand) $150 maximum copay (non-preferred brand)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% coinsurance	Services at non-participating ambulatory surgical facilities not covered.
	Physician / surgeon fees	No charge	20% coinsurance	Preauthorization is required.[3]
If you need immediate medical attention	Emergency room services	$100 copay/service	$100 copay/service	Deductible doesn't apply. Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	Deductible doesn't apply.
	Urgent care	$50 copay/service	20% coinsurance	Deductible doesn't apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% coinsurance	Preauthorization is required.[3]
	Physician / surgeon fees	No charge	20% coinsurance	----------none----------

[3] Preauthorization may apply. See your contract for a list of services requiring Preauthorization and penalties for failure to obtain Preauthorization.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/visit	20% coinsurance	----------none----------
	Mental/Behavioral health inpatient services	No charge	50% coinsurance	----------none----------
	Substance use disorder outpatient services	No charge	20% coinsurance	----------none----------
	Substance use disorder inpatient services	No charge	50% coinsurance	----------none----------
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	----------none----------
	Delivery and all inpatient services	No charge	50% coinsurance	----------none----------
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	After 90 visits, not covered. Preauthorization is required.[3]
	Rehabilitation services	$30 copay/visit	20% coinsurance	Therapy visit limit: Speech 30, occupational 30, and respiratory 30.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	No charge	50% coinsurance	After 100 days, not covered.
	Durable medical equipment	No charge	20% coinsurance	Preauthorization required on items greater than or equal to $500.[3]
	Hospice service	No charge	20% coinsurance	----------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----------

[3] Preauthorization may apply. See your contract for a list of services requiring Preauthorization and penalties for failure to obtain Preauthorization.

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
- Bariatric surgery (unless medically necessary)
- Cosmetic surgery
- Dental care
- Glasses
- Habilitation services
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care
- 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 & your costs for these services.)

- Chiropractic care
- Infertility
- Most coverage provided outside the United States.
- See www.bcbs.com/shop-for-health-insurance/coverage-home-and-away.html
- Non-emergency care when traveling outside the U.S.
- Routine maternity

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 **1-800-962-2242**. 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 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: Capital BlueCross at 1-800-962-2242. You may also contact the Pennsylvania Insurance Department at 1-877-881-6388 or www.insurance.pa.gov. If your group is subject to ERISA, you may contact the Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For additional assistance, you may contact the Pennsylvania consumer assistance line at 1-877-881-6388 or ra-in-consumer@state.pa.us.

Language Access Services:

Para obtener asistencia en Espanol, llame al 1-800-962-2242.

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 also will 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** $6,840
- **Patient pays** $700

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	$500
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$700**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,720
- **Patient pays** $1,680

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits & Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$100
Coinsurance	$1,000
Limits or exclusions	$80
Total	**$1,680**

Note: These numbers do NOT assume the patient is participating in our diabetes wellness program. If you have diabetes and participate in the wellness program, your costs may be lower. For more information about the diabetes wellness program, please contact us at 1-800-892-3033.

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 to 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.

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.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

1 Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

2 Member cost share may be reduced by employer participation in an HRA (Health Reimbursement Account), HSA (Health Savings Account), or FSA (Flexible Spending Account).