Administered by Capital BlueCross[1]

PPO H S A/with drug

Coverage Period: 1/1/2017 - 12/31/2017

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

Coverage for: All **| Plan Type:** PPO HSA

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 **https://www.capbluecross.com/sbcs** or by calling **1-800-962-2242**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,300**/person/**$2,600**/family. **Deductible** applies to all services, including prescription drug, before any copayment or coinsurance are applied. Doesn't apply to network preventive services.	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, **$6,550**/person/**$13,100**/family; combined out-of-pocket limit for 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, premiums, 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. Chiropractic not covered after 20 visits.
	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]

[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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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	Copay waived if admitted inpatient.
	Emergency medical transportation	No charge	No charge	----------none----------
	Urgent care	$50 copay/service	20% coinsurance	----------none----------
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		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
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	20% coinsurance	After 90 visits, not covered. Preauthorization is required.[3]
	Rehabilitation services	$30 copay/visit	20% coinsurance	30 visit limit
	Habilitation services	$30 copay/visit	20% coinsurance	30 visit limit
	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
- 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 treatment
- Most coverage provided outside the United States.
- See www.bcbs.com/already-a-member/traveling-outside-of-the.html
- Non-emergency care when traveling outside the U.S.

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.

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** $6,030
- **Patient pays** $1,510

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	$1,300
Copays	$0
Coinsurance	$10
Limits or exclusions	$200
Total	**$1,510**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,120
- **Patient pays** $2,280

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	$1,300
Copays	$0
Coinsurance	$900
Limits or exclusions	$80
Total	**$2,280**

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 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.

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.**

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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).

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Nondiscrimination and Foreign Language Assistance Notice

At Capital BlueCross and our family of companies, our customers and the community we serve are at the heart of everything we do. We know health insurance is complicated, and we're here to make it simple so you can focus on living healthy.

Capital BlueCross and its family of companies comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Capital BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Capital BlueCross provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters or written information in other formats (large print, audio, accessible electronic format, other formats). Capital BlueCross provides free language service to people whose primary language is not English, such as: qualified interpreters, and information written in other languages.

If you need these services, contact our Civil Rights Coordinator.

If you believe that Capital BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age disability, or sex, you can file a grievance with our Civil Rights Coordinator at Capital BlueCross, P.O. Box 779880, Harrisburg, PA 17177-9880, call 800.417.7842 (TTY: 711), fax, 855.990.9001 or email at CRC@capbluecross.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW., Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you, or someone you're helping, has questions about your health plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800.962.2242 (TTY: 711).

Spanish—Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de su plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800.962.2242 (TTY: 711).

Chinese—如果您，或是您正在協助的對象，有關於您的健康計劃方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 800.962.2242 (TTY: 711)。

Vietnamese—Nếu qu' vị, hay người mà qu' vị đang giúp đỡ, có câu hỏi về chương trình bảo hiểm sức khỏe của bạn, qu' vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800.962.2242 (TTY: 711).

Russian—Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Планирование Вашего здоровья, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 800.962.2242 (TTY: 711).

Pennsylvanian Dutch—"Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut dye zunheit, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 800.962.2242 uffrufe (TTY: 711).

Korean—만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 귀하의 건강보험 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는800.962.2242 (TTY: 711) 로 전화하십시오.

Italian—Se tu o qualcuno che stai aiutando avete domande su plan di il tuo programma sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 800.962.2242 (TTY: 711).

Arabic—

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص لخطة الصحية الخاصة بك ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 800.962.2242 (TTY: 711) .

French—Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de votre programme de santé, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800.962.2242 (TTY: 711).

German—Falls Sie oder jemand, dem Sie helfen, Fragen zum durch Ihre Krankenversicherung haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

Gujarati—જો તમને, અથવા કોઈ તમને મદદ કરી રહ્યું છે, તેમને તમારા આરોગ્યના આયોજન અંગે પ્રશ્નો છે, તો તમને કોઈ પણ ખર્ચ વિના મદદ મેળવવાનો અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા, કૃપયા 800.962.2242 (TTY: 711) પર કોલ કરો.

Polish—Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Twojego ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 800.962.2242 (TTY: 711).

French Creole—Si oumenm oswa yon moun w ap ede gen kesyon konsènan plan sante w, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 800.962.2242 (TTY: 711).

Cambodian–Mon-Khmer—ប្រសិនបើអ្នក ឬនរណាម្នាន ក់ដែលអ្នកកំពុងដែជួយ ម្នានសំណួ រអ្ំពី គម្រោងសុខភាពរបស់អ្នក បេ, អ្នកម្នានសិេធិេេួលជំនួយនិងព័ែ៌ម្នាន ជៅកនុងភា សា ររស់អ្នក ជោយមិនអ្ស់ប្ាក់ ។ បែើមបីនិយាយជាមួយអ្នករកដប្រ សូម 800.962.2242 (TTY: 711) ។

Portuguese—Se você, ou alguém a quem você está ajudando, tem perguntas sobre o o seu plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 800.962.2242 (TTY: 711).