REFERENCE GUIDE
FOR MEDICAL COVERAGE

2015

This guide contains all of the information needed to understand your 2015 medical coverage with Lehigh University.

WHERE TO GO FOR HELP		
PROVIDER	**TELEPHONE NUMBER**	**WEB ADDRESS**
Capital BlueCross and Keystone Health Plan Central **Group #00515044**	800-216-9741	www.capbluecross.com
Integrated Behavioral Health **(Mental Health/Substance Abuse benefits in *Keystone Health Plan* and *PPO 100)***	800-395-1616	www.ibhcorp.com/ User ID: lehigh Password: univ03
Magellan Health Services **(Mental Health/Substance Abuse benefits in *CMM* and *PPO 80*)**	866-322-1657	www.magellanhealth.com/MBH
Express Scripts (Prescription plan) **Group #LEHIGHU**	866-383-7420	www.express-scripts.com ID: LEHIGHU
Davis Vision **Group #LHU**	877-923-2847 or 800-999-5431	www.davisvision.com/ Control Code: 4100
United Concordia Dental **Group #250021021**	800-332-0366	www.ucci.com
WageWorks (Flexible Spending Account Administration)	855-774-7441	www.wageworks.com
Lehigh Human Resources 428 Brodhead Avenue Bethlehem, PA 18015	610-758-3900 610-758-6226 (fax)	https://hr.lehigh.edu

Medical Coverage

Medical Coverage Plans Offered by Lehigh

Medical coverage is one of the most important benefits employees choose. Lehigh offers three different types of medical coverage plans to meet your needs, and, if applicable, the needs of your family. Having that range of choices makes the decision a complex one as well. Selecting the medical coverage plan that's best for you requires some study and thought.

To help you, we have organized information about the University's medical plans into several types of summaries following the Affordable Care Act required summaries of benefits and coverage, on page 56). The first compares plan features or structures. The second compares plan benefit costs and coverage levels. The third provides brief narrative descriptions of each plan. Benefit Highlight Sheets are provided by Capital BlueCross. These are accompanied by a Schedule of Preventive Care Services and a description of their Preauthorization Program. Finally, there are summaries and details of the managed behavioral health care plans associated with our medical insurance. The combination of these summaries may make it easier for you to feel comfortable that you've chosen the best plan for 2014.

No Preexisting Conditions Clauses

None of Lehigh's medical plans has a preexisting conditions clause. Each University-sponsored medical plan will begin to offer benefits for all covered services and supplies from the first day of coverage.

Notices Required By the Patient Protection and Affordable Care Act

RETROACTIVE CANCELLATION OF COVERAGE (RESCISSION)

Your medical benefit cannot be cancelled retroactively except in the case of fraud, intentional misrepresentation of material fact, or failure to pay required contributions on a timely basis. A 30 day notice will be provided if coverage is rescinded. An example of fraud or intentional misrepresentation may include things such as retaining your former spouse on your medical benefits after your divorce decree is final. As a University medical plan participant, it is your responsibility to notify Human Resources of any changes to a dependent's status within 30 days of a status change event. Failure to provide timely notice to Human Resources constitutes intentional misrepresentation of material fact.

THE DESIGNATION OF PRIMARY CARE PROVIDERS

The Keystone Health Plan Central Health Maintenance Organization Plan (KHPC) generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the plan network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of participating primary care providers, contact the plan at 800-216-9741.

You do not need prior authorization from KHPC or from any other person (including your primary care doctor) in order to obtain access to obstetrical or gynecological care from a health care professional in the plan network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan at 800-216-9741.

AVAILABILITY OF SUMMARY HEALTH INFORMATION

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available beginning on page 15 of this document, as well as on the web at: https://hr.lehigh.edu/Open-Enrollment-Central . A paper copy is also available, free of charge, by calling 610-758-3900.

The following notice is required by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2014. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

ALABAMA – Medicaid Website: http://www.medicaid.alabama.gov	MASSACHUSETTS – Medicaid and CHIP Website: http://www.mass.gov/MassHealth	PENNSYLVANIA – Medicaid Website: http://www.dpw.state.pa.us/hipp
ALASKA – Medicaid Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890	MINNESOTA – Medicaid Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	RHODE ISLAND – Medicaid Website: www.ohhs.ri.gov Phone: 401-462-5300
ARIZONA – CHIP Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437	MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	SOUTH CAROLINA – Medicaid Website: http://www.scdhhs.gov Phone: 1-888-549-0820
COLORADO – Medicaid Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943	MONTANA – Medicaid Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084	SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
FLORIDA – Medicaid Website: https://www.flmedicaidtplrecovery.com/	NEBRASKA – Medicaid Website: www.ACCESSNebraska.ne.gov	TEXAS – Medicaid Website: https://www.gethipptexas.com/
GEORGIA – Medicaid Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)	NEVADA – Medicaid Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	UTAH – Medicaid and CHIP Website: http://health.utah.gov/upp Phone: 1-866-435-7414
IDAHO – Medicaid Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx	NEW HAMPSHIRE – Medicaid Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218	VERMONT– Medicaid Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
INDIANA – Medicaid Website: http://www.in.gov/fssa Phone: 1-800-889-9949	NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	VIRGINIA – Medicaid and CHIP Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
IOWA – Medicaid Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	NEW YORK – Medicaid Website: http://www.nyhealth.gov/health_care/medicaid/	WASHINGTON – Medicaid Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
KANSAS – Medicaid Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	NORTH CAROLINA – Medicaid Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100	WEST VIRGINIA – Medicaid Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
KENTUCKY – Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	NORTH DAKOTA – Medicaid Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/	WISCONSIN – Medicaid Website: http://www.badgercareplus.org/pubs/p-10095.htm
LOUISIANA – Medicaid Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	WYOMING – Medicaid Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531
MAINE – Medicaid Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740	OREGON – Medicaid Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	

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 documents at www.capbluecross.com; www.express-scripts.com; www.ibhcorp.com; and www.davisvision.com. See phone numbers on bottom of this page.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$600**/person **$1,800**/family. Does not apply to network preventive services, prescription drugs, or vision costs.	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 for services from participating providers. No limit for care from non-participating providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share 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, pharmacy coinsurance, vision care costs, and health care this plan does not 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. See www.capbluecross.com **or call 1-800-962-2242** for a list of participating providers. See www.davisvision.com or call **1-800-999-5431** for vision care 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 5. See your policy or plan document for additional information about **excluded services**.

Questions: About health care coverage: **1-800-216-9741** or www.capbluecross.com; about prescription drug coverage: **1-866-383-7420** or www.express-scripts.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

- **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**, **copayments** and **coinsurance** amounts.

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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	20% coinsurance	——————none——————
	Specialist visit	20% coinsurance	20% coinsurance	——————none——————
	Other practitioner office visit	20% coinsurance for chiropractic	20% coinsurance for chiropractic	Acupuncture not covered.
	Preventive care/screening/immunization	No charge	Mandated screenings and immunizations: 20% coinsurance; Routine physical exams: Not covered	Deductible does not apply to services at participating providers.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance for lab, tests, and outpatient radiology.	20% coinsurance for lab, tests, and outpatient radiology.	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	——————none——————

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or call **1-866-383-7420.**	Generic drugs	10% coinsurance (retail and mail order)	10% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Non-preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Specialty drugs	20% coinsurance	Not covered	Some drugs may require purchase through Accredo Specialty pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	Services at non-participating ambulatory surgical facilities 20% coinsurance.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	Preauthorization is required.
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	Deductible does not apply to services at in-network participating providers.
	Emergency medical transportation	20% coinsurance	20% coinsurance	————————none————————
	Urgent care	20% coinsurance	20% coinsurance	Deductible does not apply for services at in-network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Preauthorization is required.
	Physician/surgeon fee	20% coinsurance	20% coinsurance	————————none————————

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	20% coinsurance	20% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	——————none——————
	Substance use disorder outpatient services	20% coinsurance	20% coinsurance	——————none——————
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	——————none——————
If you are pregnant	Prenatal and postnatal care	20% coinsurance	20% coinsurance	——————none——————
	Delivery and all inpatient services	20% coinsurance	20% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	After 120 visits, not covered. Preauthorization is required.
	Rehabilitation services	20% coinsurance	20% coinsurance	——————none——————
	Habilitation services	Not covered	Not covered	——————none——————
	Skilled nursing care	20% coinsurance	20% coinsurance	After 120 days, not covered.
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is required on items greater than or equal to $500.
	Hospice service	20% coinsurance	20% coinsurance	——————none——————
If your child needs dental or eye care **More information about participating providers and vision care benefits are available at www.davisvision.com or call 1-800-999-5431.**	Eye exam	No charge	Full cost less $32	Limited to one exam per year
	Glasses	No charge for standard lenses and select frames; Amount over $60 for provider frames	Full cost less $55 for standard lenses and any frame	Limited to one pair of glasses per 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.)

- Acupuncture
- Bariatric surgery (unless medically necessary)
- Cosmetic surgery
- Dental care
- Habilitation services
- Hearing aids
- Long term care
- Routine foot care (unless medically necessary)
- Weight loss programs

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.)

- Chiropractic care
- Infertility treatment ($2,500 benefit lifetime maximum/subscriber and spouse each)
- Non-emergency care when traveling outside the U.S. - Most coverage provided outside the United States. See www.bcbs.com/shop-for-health-insurance/coverage-home-and-away.html
- Private-duty nursing
- Routine eye care

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 1-800-216-9741. 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:

12 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:

- Regarding medical claims: Capital Blue Cross at 1-800-962-2242.
- Regarding drug coverage, call the number on the back of your prescription benefit card or visit www.express-scripts.com.
- Regarding your vision care coverage, call 1-800-999-5432 or visit www.davisvision.com.

You may also contact the Pennsylvania Insurance Department at 1-877-881-6388 or www.insurance.pa.gov or the U.S. 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@pa.gov.

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.**

13

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** $5,900
- **Patient pays** $1,640

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	$600
Copays	$0
Coinsurance	$1,040
Limits or exclusions	$0
Total	**$1,640**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,860
- **Patient pays** $1,540

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	$600
Copays	$0
Coinsurance	$940
Limits or exclusions	$0
Total	**$1,540**

Questions and answers about the Coverage Examples:

Questions: About health care coverage: **1-800-216-9741** or www.capbluecross.com; about prescription drug coverage: **1-866-383-7420** or www.express-scripts.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

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.

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 documents at www.capbluecross.com; www.express-scripts.com; www.ibhcorp.com; and www.davisvision.com. See phone numbers on bottom of this page.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**/person for participating providers. **$500**/person for non-participating providers. Does not apply to professional services with co-pays, prescription drugs, or vision costs.	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 for in-network care. No limit for out-of-network care.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share 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, pharmacy coinsurance, vision care costs, and health care this plan does not 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. See www.capbluecross.com **or call 1-800-962-2242** for a list of participating providers. Call **IBH** at **1-800-395-1616** for Mental/Behavioral Health and Substance Abuse participating providers. See www.davisvision.com or call **1-800-999-5431** for vision 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 written 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**, **copayments** and **coinsurance** amounts.

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	$20 copay/visit	20% coinsurance	——————none——————
	Specialist visit	$20 copay/visit	20% coinsurance	——————none——————
	Other practitioner office visit	No charge for chiropractic	20% coinsurance for chiropractic	Acupuncture not covered.
	Preventive care/screening/immunization	No charge	Mandated screenings and immunizations: 20% coinsurance; Routine physical exams: Not covered	——————none——————
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	——————none——————

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 or call **1-866-383-7420.**	Generic drugs	10% coinsurance (retail and mail order)	10% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Non-preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Specialty drugs	20% coinsurance	Not covered	Some drugs may require purchase through Accredo Specialty pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Services at out-of-network ambulatory surgical facilities: 20% coinsurance.
	Physician/surgeon fees	No charge	20% coinsurance	Preauthorization is required.
If you need immediate medical attention	Emergency room services	$35 copay/service	20% coinsurance	——————none——————
	Emergency medical transportation	No charge	20% coinsurance	——————none——————
	Urgent care	$20 copay/service	20% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Preauthorization is required.
	Physician/surgeon fee	No charge	20% coinsurance	——————none——————

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 More information is available at www.ibhcorp.com or **1-800-395-1616.**	Mental/Behavioral health outpatient services	$20 copay/visit	20% coinsurance	Some services require pre-certification.
	Mental/Behavioral health inpatient services	No charge	20% coinsurance	Pre-certification required. 50% co-insurance for services provided without pre-authorization.
	Substance use disorder outpatient services	$20 copay/visit	20% coinsurance	Some services require pre-certification.
	Substance use disorder inpatient services	No charge	20% coinsurance	Pre-certification required. 50% co-insurance for services provided without pre-authorization.
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	——————none——————
	Delivery and all inpatient services	No charge	20% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	After 50 visits, not covered. Preauthorization is required.
	Rehabilitation services	No charge	20% coinsurance	Therapy visit limit: Physical 30, speech 30, and occupational 30.
	Habilitation services	Not covered	Not covered	——————none——————
	Skilled nursing care	No charge	20% coinsurance	After 100 days, not covered.
	Durable medical equipment	No charge	20% coinsurance	Preauthorization is required on items greater than or equal to $500.
	Hospice service	No charge	20% coinsurance	——————none——————
If your child needs dental or eye care **-More information about participating providers and vision care benefits are available at www.davisvision.com or call 1-800-999-5431**	Eye exam	No charge	Full cost less $32	Limited to one exam per year
	Glasses	No charge- standard lenses and select frames; Amount over $60 for provider frames	Full cost less $55 for standard lenses and any frame	Limited to one pair of glasses per 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.)

- Acupuncture
- Bariatric surgery (unless medically necessary)
- Cosmetic surgery
- Dental care
- Habilitation services
- Hearing aids
- Long term care
- Routine foot care (unless medically necessary)
- Weight loss programs

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.)

- Chiropractic care
- Infertility treatment ($2,500 benefit lifetime maximum/subscriber and spouse each)
- Non-emergency care when traveling outside the U.S. - Most coverage provided outside the United States. See www.bcbs.com/shop-for-health-insurance/coverage-home-and-away.html
- Private-duty nursing
- Routine eye care

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 1-800-216-9741. 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:

21 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:

- Regarding medical claims: Capital Blue Cross at 1-800-962-2242.
- Regarding drug coverage, call the number on the back of your prescription benefit card or visit www.express-scripts.com.
- Regarding mental/behavioral health and substance abuse coverage, call 1-800-395-1616 or visit www.ibhcorp.com.
- Regarding your vision care coverage, call 1-800-999-5432 or visit www.davisvision.com.

You may also contact the Pennsylvania Insurance Department at 1-877-881-6388 or www.insurance.pa.gov or the U.S. 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@pa.gov.

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.**

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** $7,380
- **Patient pays** $160

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	$0
Copays	$120
Coinsurance	$40
Limits or exclusions	$0
Total	**$160**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,700
- **Patient pays** $700

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	$0
Copays	$120
Coinsurance	$580
Limits or exclusions	$0
Total	**$700**

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.

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 documents at www.capbluecross.com; www.express-scripts.com; www.ibhcorp.com; and www.davisvision.com. See phone numbers on bottom of this page.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200**/person **$600**/family for participating providers. **$500**/person for non-participating providers. Does not apply to professional services with co-pays, network preventive services, prescription drugs, or vision costs.	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 for in-network care. No limit for out-of-network care.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share 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, pharmacy coinsurance, vision care costs, and health care this plan does not 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. See www.capbluecross.com **or call 1-800-962-2242** for a list of participating providers. See www.davisvision.com or call **1-800-999-5431** for vision care 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 5. See your policy or plan document for additional information about **excluded services**.

Questions: About health care coverage: **1-800-216-9741** or www.capbluecross.com; about prescription drug coverage: **1-866-383-7420** or www.express-scripts.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

- **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**, **copayments** and **coinsurance** amounts.

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	$20 copay/visit	30% coinsurance	——————none——————
	Specialist visit	$20 copay/visit	30% coinsurance	——————none——————
	Other practitioner office visit	20% coinsurance for chiropractic	30% coinsurance for chiropractic	Acupuncture not covered.
	Preventive care/screening/immunization	No charge	Mandated screenings and immunizations: 30% coinsurance; Routine physical exams: Not covered	Deductible does not apply to services at participating in-network providers.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance for lab, tests, and outpatient radiology.	30% coinsurance for lab, tests, and outpatient radiology.	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	——————none——————

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 or call **1-866-383-7420.**	Generic drugs	10% coinsurance (retail and mail order)	10% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Non-preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Specialty drugs	20% coinsurance	Not covered	Some drugs may require purchase through Accredo Specialty pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Services at non-participating ambulatory surgical facilities 30% coinsurance.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Preauthorization is required.
If you need immediate medical attention	Emergency room services	$35 copay/service	30% coinsurance	Deductible does not apply to services at in-network participating providers.
	Emergency medical transportation	20% coinsurance	30% coinsurance	——————none——————
	Urgent care	$20 copay/service	30% coinsurance	Deductible does not apply for services at in-network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Preauthorization is required.
	Physician/surgeon fee	20% coinsurance	30% coinsurance	——————none——————

27

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	$20 copay/visit	30% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	30% coinsurance	——————none——————
	Substance use disorder outpatient services	$20 copay/visit	30% coinsurance	——————none——————
	Substance use disorder inpatient services	20% coinsurance	30% coinsurance	——————none——————
If you are pregnant	Prenatal and postnatal care	20% coinsurance	30% coinsurance	——————none——————
	Delivery and all inpatient services	20% coinsurance	30% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	After 90 visits, not covered. Preauthorization is required.
	Rehabilitation services	20% coinsurance	30% coinsurance	——————none——————
	Habilitation services	Not covered	Not covered	——————none——————
	Skilled nursing care	20% coinsurance	30% coinsurance	After 100 days, not covered.
	Durable medical equipment	20% coinsurance	30% coinsurance	Preauthorization is required on items greater than or equal to $500.
	Hospice service	20% coinsurance	30% coinsurance	——————none——————
If your child needs dental or eye care **More information about participating providers and vision care benefits are available at www.davisvision.com or call 1-800-999-5431.**	Eye exam	No charge	Full cost less $32	Limited to one exam per year
	Glasses	No charge for standard lenses and select frames; Amount over $60 for provider frames	Full cost less $55 for standard lenses and any frame	Limited to one pair of glasses per 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.)

- Acupuncture
- Bariatric surgery (unless medically necessary)
- Cosmetic surgery
- Dental care
- Habilitation services
- Hearing aids
- Long term care
- Routine foot care (unless medically necessary)
- Weight loss programs

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.)

- Chiropractic care
- Infertility treatment ($2,500 benefit lifetime maximum/subscriber and spouse each)
- Non-emergency care when traveling outside the U.S. - Most coverage provided outside the United States. See www.bcbs.com/shop-for-health-insurance/coverage-home-and-away.html
- Private-duty nursing
- Routine eye care

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For more information on your rights to continue coverage, contact the plan at 1-800-216-9741. 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.

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- Regarding medical claims: Capital Blue Cross at 1-800-962-2242.
- Regarding drug coverage, call the number on the back of your prescription benefit card or visit www.express-scripts.com.
- Regarding your vision care coverage, call 1-800-999-5432 or visit www.davisvision.com.

You may also contact the Pennsylvania Insurance Department at 1-877-881-6388 or www.insurance.pa.gov or the U.S. 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@pa.gov.

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.**

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.

32

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,380
- **Patient pays** $1,160

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	$200
Copays	$120
Coinsurance	$840
Limits or exclusions	$0
Total	**$1,160**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,200
- **Patient pays** $1,200

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	$200
Copays	$120
Coinsurance	$880
Limits or exclusions	$0
Total	**$1,200**

Questions and answers about the Coverage Examples:

Questions: About health care coverage: **1-800-216-9741** or www.capbluecross.com; about prescription drug coverage: **1-866-383-7420** or www.express-scripts.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary beginning on page 52.

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.

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 documents at www.capbluecross.com; www.express-scripts.com; www.ibhcorp.com; and www.davisvision.com. See phone numbers on bottom of this page.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
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 for in-network care. No limit for out-of-network care.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share 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, pharmacy coinsurance, vision care costs, and health care this plan does not 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. See www.capbluecross.com **or call 1-800-962-2242** for a list of participating providers. Call **IBH** at **1-800-395-1616** for Mental/Behavioral Health and Substance Abuse participating providers. See www.davisvision.com or call **1-800-999-5431** for vision care 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?	Yes. You need a written referral to see a specialist.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
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**, **copayments** and **coinsurance** amounts.

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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not covered.	Additional $10 copay required after hours.
	Specialist visit	$20 copay/visit	Not covered.	————————none————————
	Other practitioner office visit	No charge for chiropractic	Not covered for chiropractic	Acupuncture not covered. 2 weeks (14 consecutive days) for chiropractic. Preauthorization is required for manipulation therapy.
	Preventive care/screening/immunization	No charge	Not covered.	————————none————————
If you have a test	Diagnostic test (x-ray, blood work)	No charge for lab or tests.	Not covered.	————————none————————
	Imaging (CT/PET scans, MRIs)	No charge.	Not covered.	Preauthorization is required.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or call **1-866-383-7420.**	Generic drugs	10% coinsurance (retail and mail order)	10% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Non-preferred brand drugs	20% coinsurance (retail and mail order)	20% coinsurance plus amount over Express Scripts allowable	Covers 30 to 90 day supply. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Specialty drugs	20% coinsurance	Not covered	Some drugs may require purchase through Accredo Specialty pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	——————none——————
	Physician/surgeon fees	No charge	Not covered	Preauthorization is required.
If you need immediate medical attention	Emergency room services	$25 copay/service	$25 copay/service	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	——————none——————
	Urgent care	$20 copay/service	Not covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization is required.
	Physician/surgeon fee	No charge	Not covered	——————none——————

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 More information is available at www.ibhcorp.com or **1-800-395-1616.**	Mental/Behavioral health outpatient services	$20 copay/visit	Not covered	Some services require pre-certification.
	Mental/Behavioral health inpatient services	No charge	Not covered	Pre-certification required. 50% co-insurance for services provided without pre-authorization.
	Substance use disorder outpatient services	$20 copay/visit	Not covered	Some services require pre-certification.
	Substance use disorder inpatient services	No charge	Not covered	Pre-certification required. 50% co-insurance for services provided without pre-authorization.
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	——————none——————
	Delivery and all inpatient services	No charge	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	After 100 visits, not covered. Preauthorization is required.
	Rehabilitation services	No charge	Not covered	Therapy limited to 30 visits
	Habilitation services	Not covered	Not covered	——————none——————
	Skilled nursing care	No charge	Not covered	After 60 days, not covered. Skilled nursing limit combined with acute inpatient rehabilitation limit.
	Durable medical equipment	No charge	Not covered	Preauthorization is required on items greater than or equal to $500.
	Hospice service	No charge	Not covered	——————none——————

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 your child needs dental or eye care **-More information about participating providers and vision care benefits are available at www.davisvision.com or call 1-800-999-5431**	Eye exam	No charge	Full cost less $32	Limited to one exam per year
	Glasses	No charge -standard lenses and select frames; Amount over $60 for provider frames	Full cost less $55 for standard lenses and any frame	Limited to one pair of glasses per 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.)

- Acupuncture
- Bariatric surgery (unless medically necessary)
- Cosmetic surgery
- Dental care
- Habilitation services
- Hearing aids
- Long term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care (unless medically necessary)
- Weight loss programs

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.)

- Chiropractic care (with plan limitations)
- Infertility treatment ($2,500 benefit lifetime maximum/subscriber and spouse each)
- Private-duty nursing
- Routine eye care

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 1-800-216-9741. 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:

40 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:

- Regarding medical claims: Capital Blue Cross at 1-800-962-2242.
- Regarding drug coverage, call the number on the back of your prescription benefit card or visit www.express-scripts.com.
- Regarding mental/behavioral health and substance abuse coverage, call 1-800-395-1616 or visit www.ibhcorp.com.
- Regarding your vision care coverage, call 1-800-999-5432 or visit www.davisvision.com.

You may also contact the Pennsylvania Insurance Department at 1-877-881-6388 or www.insurance.pa.gov or the U.S. 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@pa.gov.

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.**

41

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.

42

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,380
- **Patient pays** $160

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	$0
Copays	$120
Coinsurance	$40
Limits or exclusions	$0
Total	**$160**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,700
- **Patient pays** $700

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	$0
Copays	$120
Coinsurance	$580
Limits or exclusions	$0
Total	**$700**

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.

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Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Bold blue text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal

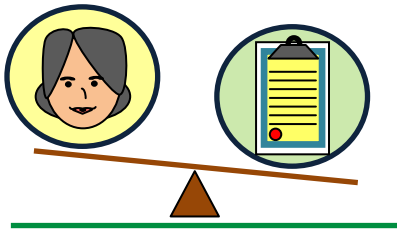
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may ***not*** balance bill you for covered services.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance ***plus*** any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.



Jane pays 20% | Her plan pays 80%

(See page 4 for a detailed example.)

Complications of Pregnancy

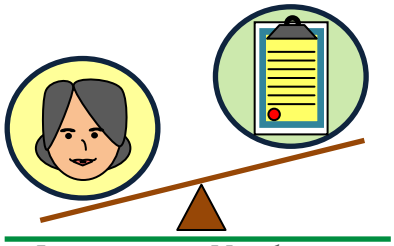
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



Jane pays 100% | Her plan pays 0%

(See page 4 for a detailed example.)

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an emergency medical condition.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

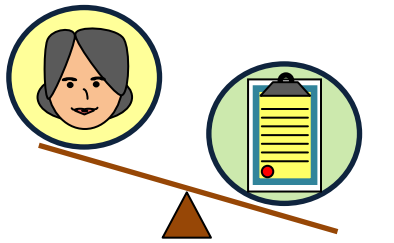
Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do ***not*** contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

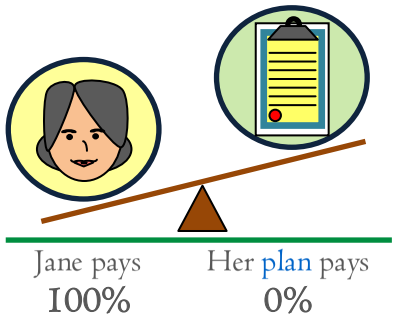
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

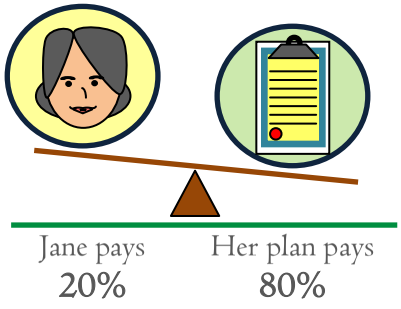


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs

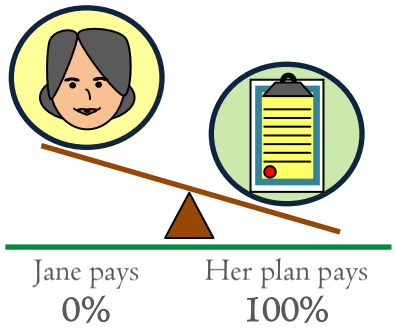


Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

more costs



Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

Understanding Medical Coverage Plan Language

The following are definitions of terms used in the description of medical coverage. Understanding these terms will make it easier for you to compare the benefits provided under each of the plans.

Allowed Charge: That portion of a charge that the plan determines is reasonable for covered services that have been provided to the patient. Also known as the "allowance." Amounts in excess of the allowed charge are not paid by the plan. If the services were provided by a participating provider, the amount in excess of the allowed charge is waived by the provider. If the services were provided by a non-participating provider, the patient may be responsible for paying the additional amount (see Balance Billing).

Balance Billing: Occurs when a provider of services or supplies refuses to accept the payment level determined by a medical plan as payment in full. The provider then bills the insured for the amount of the charge that exceeds plan payment plus deductible, coinsurance, and/or copayment.

Coinsurance [CI]: The portion of a covered charge that is paid by both the insured and the plan. It is the sharing of charges as defined by the plan. Typically these amounts are expressed in terms of the "percentage paid by the plan versus percentage paid by the insured," such as 80 percent by the plan and 20 percent by you; 70 percent by the plan and 30 percent by you; or 50 percent by the plan and 50 percent by you. Coinsurance amounts may affect out-of-pocket maximums.

Copayment [CP]: A flat dollar amount paid to the provider by the insured for a covered service or supply at the time it is received. An example would be paying the physician $20 at the time of an office visit.

Covered Charge: An allowed charge for service that the plan is designed to accept and for which the plan will pay, if all other conditions (like deductibles and coinsurance) have been met. Charges that are not covered do not affect deductibles, coinsurance, or out-of-pocket maximums.

Deductible [D]: The total amount of covered charges the insured must pay in full during the plan year before any payment is made by the plan.

Out-of-pocket Maximum: The maximum amount that would be paid by the insured for covered charges during a plan year, usually a combination of deductible and coinsurance. The amount does not include plan copayments, charges for services that are not covered, and charges that are in excess of plan allowable amounts (see Balance Billing).

Preventive Care: Any covered medical service or supply that is received in the absence of symptoms or a diagnosed medical condi-tion. Preventive care includes preventive health ser-

vices like physical examinations, certain immunizations, and screening tests. Preventive care can also provide specific programs of education, exercise, or behavior modification that seek to manage disease or change lifestyle: programs for diabetes management, smoking cessation, childbirth preparation and the like. Medical plans clearly define the types of services, supplies, and programs they offer as preventive benefits and they provide them based upon protocols established in the medical community with regard to factors like frequency, patient age, and suitability. The Patient Protec-tion and Affordable Care Act also requires particular preventive services for particular individuals to be covered at no cost, provided the covered services are received from a network provider. These services can be reviewed on page 12 of this document or at https://www.healthcare.gov/what-are-my-preventive-care-benefits.

1. Plan Feature Comparison Chart						
Plan Name	***CMM Plan***	***PPO 80***		***PPO 100***		**Keystone HMO**
Plan Type	**Comprehensive Major Medical Fee for Service**	**Preferred Provider Organization**		**Preferred Provider Organization**		**Health Maintenance Organization**
		In Network	**Out of Network**	**In Network**	**Out of Network**	
Network Type						
Local Network						✓
National Network	✓	✓		✓		
Primary Care Physician						✓
Referral Required						✓
IBH Manages Mental Health/Substance Abuse Benefits				✓	✓	✓
Magellan Pre-authorizes Mental Health/Substance Abuse Benefits	✓	✓	✓			
What you pay						
Deductible	✓	✓	✓		✓	
Coinsurance	✓	✓	✓		✓	
Copayment		✓		✓		✓
Out of Network						
Higher Deductible and Coinsurance			✓		✓	
Balance Billing	✓		✓		✓	
Coverage out of network						
Routine care	✓		✓		✓	
Emergency/Urgent Care	✓		✓		✓	✓
Wellness Care						
Limited Preventive Testing	✓		✓		✓	
Broad Wellness Care		✓		✓		✓

2. Plan Benefit Comparison Chart
Your Out-of-Pocket Costs

Plan Structure	Comprehensive Major Medical Plan (CMM)	Preferred Provider Organization 80 (PPO 80)		Preferred Provider Organization 100 (PPO 100)		Keystone Health Plan Health Maintenance Organization
		In Network	Out of Network	In Network	Out of Network	
Network	National	National		National		Local
Deductible [D]	$600/person $1800/family	$200/person $600/family	$500/person		$500/person	
Coinsurance [CI]	20% up to $1000/person $3000/family	20% up to $800/person $2400/family	30%		20%	
Annual deductible and coinsurance limits	$1600/person $4800/family	$1000/person $3000/person	Unlimited		Unlimited	
Annual Out of Pocket Maximums including applicable physician copayments	$4000/person $8000/family	$4000/person $8000/family	Unlimited	$4000/person $8000/family	Unlimited	$4000/person $8000/family
Copayment [CP]		$20/doctor visit		$20/doctor visit		$20/doctor visit
Preventive Care [L]	No Cost	No Cost		No Cost		No Cost
Doctor's Office Visit	D/CI	CP	D/CI	CP	D/CI	CP
Inpatient Hospital	D/CI [P]	D/CI [P]	D/CI [P]	No Cost [P]	D/CI [P]	No Cost [P]
Outpatient Hospital	D/CI [P]	D/CI [P]	D/CI [P]	No Cost [P]	D/CI [P]	No Cost [P]
Surgical Charges, Tests, Procedures	D/CI [P]	D/CI [P]	D/CI [P]	No Cost [P]	D/CI [P]	No Cost [P]
Mental Health/Substance Abuse Outpatient [P]	D/CI [A] [P]	CP [A] [P]	D/CI [A] [P]	CP [M] [P]	D/CI [M] [P]	CP [M] [P]
Mental Health/Substance Abuse Inpatient [P]	D/CI [A] [P]	D/CI [A] [P]	D/CI [A] [P]	No Cost [M] [P]	D/CI [M] [P]	No Cost [M] [P]
Prescription Drugs	Administered by Express Scripts: 10% Generic; 20% Brand. Out of pocket maximum $2600/person, $5200 per family. More information on page 87-89. [G]					
Vision Care	Davis Vision Program. More information on page 89-90.					

[A] Preauthorization required from Magellan Behavioral Health, Contact Magellan directly to coordinate services.
[CI] Coinsurance: Portion of a covered charge paid by both the insured and the plan.
[CP] Copayment: Flat dollar amount paid to provider by the insured for a covered service or supply at the time it is received.
[D] Deductible: Total amount of covered charges the insured must pay in full during plan year before any payment is made by plan.
[G] $25 generic prescription maximum per prescription, per month; $50 brand prescription maximum per prescription, per month.
[L] With limitations defined by the plan or provided in the Affordable Care Act (see https://www.healthcare.gov/what-are-my-preventive-care-benefits/).
[M] Managed by Integrated Behavior Health (IBH). Contact IBH directly to coordinate services.
[P] Preauthorization required: 30 percent coinsurance if Capital Blue Cross procedures not followed in the CMM Plan; 50 percent coinsurance out-of-network in PP080 and PPO 100; failure to preauthorize with IBH results in no benefit.

See also: Important Notices and Disclosures about the medical plan on pages 8 through 10.

3. Narrative Plan Descriptions

No Coverage is an option only for individuals who have coverage through another source. All other faculty and staff are required to select and pay for one of the medical plans made available by the University.

CMM Plan is a **Capital BlueCross (CBC)** traditional fee-for-service comprehensive major medical plan that allows you to see any health care provider you choose. Charges for services are submitted to the plan and the plan determines what it will pay based on defined coverage levels. Unpaid balances are your responsibility. The plan is designed to pay the cost of treating and caring for participants when they are ill. It does *not* cover wellness care, except for a limited number of items listed below. This plan provides you with the greatest freedom of choice but also exposes you to the greatest out-of-pocket cost, including deductibles, coinsurance, and balance billing from physicians who do not participate with the CBC network.

- Preauthorization is required for hospital stays and many elective surgeries.
- Covered wellness testing is limited to annual gynecological exams, annual pap smears, screening mammograms, sigmoidoscopies, colonoscopies, and PSA tests — the availability of which is governed by generally accepted medical protocols — as well as preventive care benefits defined by The Affordable Care Act.
- To speak to a plan representative to ask coverage questions or identify participating doctors or hospitals, call 800-216-9741. To find a provider online, see the *Finding a Participating Provider* box..
- Magellan Behavioral Health will preauthorize behavioral inpatient care and partial hospitalization benefits. To receive reimbursement, services must be preauthorized.
- Prescription drug (through **Express Scripts**) and vision care benefits (through **Davis Vision)** are also provided under the *CMM Plan*.

PPO 80 is a CBC preferred provider organization (PPO) medical plan with an extensive network of physicians and hospitals across the United States. You may see any provider in the network, including specialists, without selecting a primary care physician or having a referral. Wellness care is covered if it is received from a network provider.

- You pay a small copayment for each doctor visit. Deductibles, coinsurance payments, and out-of-pocket limits similar to those in a fee-for-service plan apply to other in-network services such as tests and hospitalization. The plan is designed to give you access to flat dollar copayments for doctor visits, provide coverage for wellness care, and give you the freedom to receive care without the paperwork hassle of referrals.
- You may also receive services from providers who are not part of the network. However, charges for out-of-network services, if covered, are subject to higher deductibles, higher coinsurance payments, and balance billing by the provider.
- To speak to a plan representative to ask coverage questions or identify participating doctors or hospitals, call 800-216-9741. To find a provider online, see the *Finding a Participating Provider* box.
- Magellan Behavioral Health will preauthorize behavioral inpatient care and partial hospitalization benefits. To receive reimbursement, services must be preauthorized.

Services received out of the plan's network will be subject to higher deductibles, higher co-insurance payments, and are likely to result in balance billing, as well.

- Prescription drug (through **Express Scripts**) and vision care benefits (through **Davis Vision)** are also provided under PPO80.

PPO 100 is a CBC preferred provider organization (PPO) medical plan with an extensive network of physicians and hospitals across the United States. You may see any provider in the network, including specialists, without selecting a primary care physician or having a referral. Wellness care is covered if it is received from a network provider.

- You pay a small copayment for each doctor visit. Other covered in-network services, such as tests and hospitalization, are paid in full. The plan is designed to give you access to flat dollar copayments for doctor visits, provide coverage for wellness care, and give you the freedom to receive care without the paperwork hassle of referrals.
- You may also receive services from providers who are not part of the network. However, charges for out-of-network services, if covered, are subject to deductible and coinsurance payments, as well as balance billing by the provider.
- To speak to a plan representative — to ask coverage questions or identify participating doctors or hospitals — call 800-216-9741. To find a provider online, see the *Finding a Participating Provider.*
- Behavioral health care benefits for PPO 100 participants are managed by Integrated Behavioral Health (IBH). In network, IBH manages the benefits through assessment, referral, case management, and claims payment. IBH uses its nationwide network of behavioral health professionals and treatment programs and facilities. Services received out of network must be preauthorized by IBH. Such out of network services will be subject to deductibles, coinsurance payments, and are likely to result in balance billing, as well.
- Prescription drug (through **Express Scripts**) and vision care benefits (through **Davis Vision)** are also provided under *PPO 100*

Keystone Health Plan Central (Keystone) is a CBC health maintenance organization or HMO. To receive benefits through the plan you are required to select a primary care physician (PCP). All services are received from the PCP or by referral from the PCP to another provider. The HMO is not obligated to pay for any care that is not initiated through the PCP.

- With Keystone, you must work within the network, use your PCP, and get referrals to see other doctors. In exchange, you enjoy the lowest premiums and highest coverage levels of the four plans available.
- To speak to a plan representative to ask coverage questions, identify participating doctors or hospitals, or to change your existing PCP, call 800-216-9741**.** To find a provider online, see the *Finding a Participating Provider.*
- Keystone participants receive behavioral health care benefits through **Integrated Behavioral Health (IBH).** IBH manages the benefits through assessment, referral, case management, and claims payment. IBH uses its nationwide network of behavioral health professionals and treatment programs and facilities. To use this benefit, all services must be preauthorized and received within the network. There are no out-of-network benefits available.
- Prescription drug (through **Express Scripts**) and vision care benefits (through **Davis Vision**) are also provided under Keystone.

The following medical plan benefit highlight sheets have been reformatted by Capital Blue Cross. These streamlined summaries no longer display all the coverage information they have in the past. Although the summaries now display less information, the University's medical plans have not changed for 2015. Please refer to the medical plan certificates of coverage (which can be found on the CampusPortal, under the "Employee" tab, in the "Human Resources" box on the upper right) for more coverage detail information.

THIS IS NOT A CONTRACT. This information highlights *some* of the benefits available through this program and is NOT intended to be a complete list or description of available services. Benefits are subject to the exclusions and limitations contained in your Certificate of Coverage (COC). Refer to your COC for benefit details.

SUMMARY OF COST-SHARING	Amounts *Members* Are Responsible For:	
	Participating Providers	***Non-Participating Providers***
Deductible (per benefit period)	$600 per member $1,800 per family	
Copayments		
• **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*)	Coinsurance applies	Coinsurance applies
• **Specialist Office Visit**	Coinsurance applies	Coinsurance applies
• **Emergency Room**	Coinsurance applies	Coinsurance applies
• **Urgent Care**	Coinsurance applies	Coinsurance applies
• **Inpatient** (Per Admission)	Coinsurance applies	Coinsurance applies
• **Outpatient Surgery Copayment** (facility)	Coinsurance applies	Coinsurance applies
Coinsurance	Coinsurance applies	Coinsurance applies
Coinsurance Out-of-Pocket Maximum *(includes Coinsurance amounts; when this amount is satisfied, no further coinsurance is applied*).	$1,000 per member $3,000 per family	
Out-of-Pocket Maximum *(includes Deductible and Coinsurance for Medical* for Participating Providers only).	$4,000 per member $8,000 per family	

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:	
		Participating Providers	***Non-Participating Providers***
PREVENTIVE CARE: *Administered in accordance with Preventive Health Guidelines and PA state mandates*			
Preventive Care Services			
• Pediatric Preventive Care		Covered in full, waive deductible	Not covered
• Adult Preventive Care		Covered in full, waive deductible	Not covered
Immunizations		Covered in full, waive deductible	20% coinsurance after deductible
Mammograms			
• Screening Mammogram	One per benefit period	Covered in full, waive deductible	20% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full, waive deductible	20% coinsurance after deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		20% coinsurance after deductible	20% coinsurance after deductible
Acute Inpatient Rehabilitation		20% coinsurance after deductible	20% coinsurance after deductible
Skilled Nursing Facility	120 days/benefit period	20% coinsurance after deductible	20% coinsurance after deductible
Surgery			
• Surgical Procedure & Anesthesia		20% coinsurance after deductible	20% coinsurance after deductible
Maternity Services and Newborn Care		20% coinsurance after deductible	20% coinsurance after deductible
Diagnostic Services			
• Radiology		20% coinsurance after deductible	20% coinsurance after deductible
• Laboratory		20% coinsurance after deductible	20% coinsurance after deductible
• Medical tests		20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Surgery		20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Therapy Services			
• Physical Medicine		20% coinsurance after deductible	20% coinsurance after deductible
• Occupational Therapy		20% coinsurance after deductible	20% coinsurance after deductible
• Speech Therapy		20% coinsurance after deductible	20% coinsurance after deductible
• Respiratory Therapy		20% coinsurance after deductible	20% coinsurance after deductible
• Manipulation Therapy		20% coinsurance after deductible	20% coinsurance after deductible
Emergency Services		20% coinsurance after deductible	
Mental Health Care Services • Inpatient Services		20% coinsurance after deductible	20% coinsurance after deductible
• Outpatient Services		20% coinsurance after deductible	20% coinsurance after deductible
Substance Abuse Services • Rehabilitation – Inpatient		20% coinsurance after deductible	20% coinsurance after deductible
• Rehabilitation – Outpatient		20% coinsurance after deductible	20% coinsurance after deductible
Home Health Care Services	120 visits/benefit period	20% coinsurance after deductible	20% coinsurance after deductible
Durable Medical Equipment (DME)		20% coinsurance after deductible	20% coinsurance after deductible
Prosthetic Appliances		20% coinsurance after deductible	20% coinsurance after deductible
Orthotic Devices		20% coinsurance after deductible	20% coinsurance after deductible

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Benefit Highlights
PPO 80 Plan
Lehigh University

THIS IS NOT A CONTRACT. This information highlights *some* of the benefits available through this program and is NOT intended to be a complete list or description of available services. Benefits are subject to the exclusions and limitations contained in your Certificate of Coverage (COC). Refer to your COC for benefit details.

SUMMARY OF COST-SHARING	Amounts *Members* Are Responsible For:	
	Participating Providers	***Non-Participating Providers***
Deductible (per benefit period)	$200 per member $600 per family	$500 per member
Copayments		
• **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*)	$20 copayment per visit	Coinsurance applies
• **Specialist Office Visit**	$20 copayment per visit	Coinsurance applies
• **Emergency Room**	$35 copayment per visit, waived if admitted	
• **Urgent Care**	$20 copayment per visit	Coinsurance applies
• **Inpatient** (Per Admission)	Coinsurance applies	Coinsurance applies
• **Outpatient Surgery Copayment** (facility)	Coinsurance applies	Coinsurance applies
Coinsurance	20% coinsurance	30% coinsurance
Coinsurance Out-of-Pocket Maximum *(includes Coinsurance amounts; when this amount is satisfied, no further coinsurance is applied*).	$800 per member $2,400 per family	Unlimited
Out-of-Pocket Maximum *(includes Deductible, Copayments and Coinsurance for Medical (including ER,* for Participating Providers only).	$4,000 per member $8,000 per family	Unlimited

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:	
		Participating Providers	***Non-Participating Providers***
PREVENTIVE CARE: *Administered in accordance with Preventive Health Guidelines and PA state mandates*			
Preventive Care Services			
• Pediatric Preventive Care		Covered in full, waive deductible	Not covered
• Adult Preventive Care		Covered in full, waive deductible	Not covered
Immunizations		Covered in full, waive deductible	30% coinsurance, waive deductible
Mammograms			
• Screening Mammogram	One per benefit period	Covered in full, waive deductible	30% coinsurance, waive deductible
• Diagnostic Mammogram		20% coinsurance after deductible	30% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full, waive deductible	30% coinsurance, waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		20% coinsurance	30% coinsurance
Acute Inpatient Rehabilitation		20% coinsurance	30% coinsurance
Skilled Nursing Facility	100 days/benefit period	20% coinsurance	30% coinsurance
Surgery			
• Surgical Procedure & Anesthesia		20% coinsurance	30% coinsurance
Maternity Services and Newborn Care		20% coinsurance	30% coinsurance
Diagnostic Services			
• Radiology		20% coinsurance	30% coinsurance
• Laboratory		20% coinsurance	30% coinsurance
• Medical tests		20% coinsurance	30% coinsurance
Outpatient Surgery		20% coinsurance	30% coinsurance
Outpatient Therapy Services			
• Physical Medicine		20% coinsurance	30% coinsurance
• Occupational Therapy		20% coinsurance	30% coinsurance
• Speech Therapy		20% coinsurance	30% coinsurance
• Respiratory Therapy		20% coinsurance	30% coinsurance
• Manipulation Therapy		20% coinsurance	30% coinsurance
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient	
Mental Health Care Services • Inpatient Services		20% coinsurance	30% coinsurance
• Outpatient Services		Copayment applies	30% coinsurance
Substance Abuse Services • Rehabilitation – Inpatient		20% coinsurance	30% coinsurance
• Rehabilitation – Outpatient		Copayment applies	30% coinsurance
Home Health Care Services	90 visits/benefit period	20% coinsurance	30% coinsurance
Durable Medical Equipment (DME)		20% coinsurance	30% coinsurance
Prosthetic Appliances		20% coinsurance	30% coinsurance
Orthotic Devices		20% coinsurance	30% coinsurance

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Benefit Highlights
PPO 100 Plan
Lehigh University

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SUMMARY OF COST-SHARING	Amounts *Members* Are Responsible For:	
	Participating Providers	***Non-Participating Providers***
Deductible (per benefit period)	Not Applicable	$500 per member
Copayments		
• **Office Visits** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*)	$20 copayment per visit	Coinsurance applies
• **Specialist Office Visit**	$20 copayment per visit	Coinsurance applies
• **Emergency Room**	$35 copayment per visit, waived if admitted	
• **Urgent Care**	$20 copayment per visit	Coinsurance applies
• **Inpatient** (Per Admission)	Covered in full	Coinsurance applies
• **Outpatient Surgery Copayment** (facility)	Covered in full	Coinsurance applies
Coinsurance	Not Applicable	20% coinsurance
Out-of-Pocket Maximum *(includes Deductible, Copayments and Coinsurance for Medical (including ER,* for Participating Providers only).	$4,000 per member $8,000 per family	Unlimited

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:	
		Participating Providers	***Non-Participating Providers***
PREVENTIVE CARE: *Administered in accordance with Preventive Health Guidelines and PA state mandates*			
Preventive Care Services			
• Pediatric Preventive Care		Covered in full	Not covered
• Adult Preventive Care		Covered in full	Not covered
Immunizations		Covered in full	20% coinsurance, waive deductible
Mammograms			
• Screening Mammogram	One per benefit period	Covered in full	20% coinsurance, waive deductible
• Diagnostic Mammogram		Covered in full	20% coinsurance after deductible
Gynecological Services			
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full, waive deductible	20% coinsurance, waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		Covered in full	20% coinsurance
Acute Inpatient Rehabilitation	60 days/benefit period	Covered in full	20% coinsurance
Skilled Nursing Facility	100 days/benefit period	Covered in full	20% coinsurance
Surgery			
• Surgical Procedure & Anesthesia		Covered in full	20% coinsurance
Maternity Services and Newborn Care		Covered in full	20% coinsurance
Diagnostic Services			
• Radiology		Covered in full	20% coinsurance
• Laboratory		Covered in full	20% coinsurance
• Medical tests		Covered in full	20% coinsurance
Outpatient Surgery		Covered in full	20% coinsurance
Outpatient Therapy Services			
• Physical Medicine	30 visits/benefit period/condition	Covered in full	20% coinsurance
• Occupational Therapy	30 visits/benefit period	Covered in full	20% coinsurance
• Speech Therapy	30 visits/benefit period	Covered in full	20% coinsurance
• Respiratory Therapy		Covered in full	20% coinsurance
• Manipulation Therapy		Covered in full	20% coinsurance
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient	
Mental Health Care Services • Inpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY	
• Outpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY	
Substance Abuse Services • Rehabilitation – Inpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY	
• Rehabilitation – Outpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY	
Home Health Care Services	50 visits/benefit period	Covered in full	20% coinsurance
Durable Medical Equipment (DME)		Covered in full	20% coinsurance
Prosthetic Appliances		Covered in full	20% coinsurance
Orthotic Devices		Covered in full	20% coinsurance

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THIS IS NOT A CONTRACT. This information highlights ***some*** of the benefits available through this program and is **NOT** intended to be a complete list or complete description of available services. Refer to your Certificate of Coverage for benefit details.

SUMMARY OF COST-SHARING	Amounts *Members* Are Responsible For:
Deductible (per benefit period)	Not Applicable
Copayments	
• **Office Visits - PCP** (*performed by a Family Practitioner, General Practitioner, Internist, Pediatrician, Preventive Medicine specialist, or participating Retail Clinic*)	$20 copayment per visit
• **Specialist Office Visit**	$20 copayment per visit
• **After Hours Office Visit** (in addition to the PCP office visit copayment)	$10 copayment per visit
• **Emergency Room**	$25 copayment per visit, waived if admitted
• **Urgent Care** – Outside service area	Covered in full, after $25 copayment (PCP or Emergency Room)
• **Urgent Care** – In service area	Covered in full after $25 copayment (additional $10 copayment for after hours visit)
• **Inpatient** (Per Admission)	Covered in full
• **Outpatient Surgery Copayment** (facility)	Not Applicable
Coinsurance	50% coinsurance, where applicable
Out-of-Pocket Maximum *(includes deductible, copayments and coinsurance for Medical (including ER) for Participating Providers only)*	$4,000 per member $8,000 per family

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:
PREVENTIVE CARE: *Administered in accordance with Preventive Health Guidelines and PA state mandates*		
Preventive Care Services		
• Pediatric Preventive Care		Covered in full
• Adult Preventive Care		Covered in full
Immunizations		Covered in full
Mammograms		
• Screening Mammogram	One per benefit period	Covered in full (no referral necessary)
• Diagnostic Mammogram		Covered in full
Gynecological Services		
• Screening Gynecological Exam & Pap Smear	One per benefit period	Covered in full (no referral necessary)
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET		
Acute Care Hospital Room & Board		Covered in full
Acute Inpatient Rehabilitation **Skilled Nursing Facility**	60 days/benefit period combined	Covered in full
Surgery		
• Surgical Procedure & Anesthesia		Covered in full
Maternity Services and Newborn Care		Covered in full
Diagnostic Services		
• Radiology		Covered in full
• Laboratory		Covered in full
• Medical tests		Covered in full
Outpatient Therapy Services		
• Physical Medicine • Occupational Therapy • Respiratory Therapy • Speech Therapy	30 (visits each type/benefit period)	Covered in full
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted inpatient
Mental Health Care Services		
• Inpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
• Outpatient Services		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
Substance Abuse Services		
• Rehabilitation – Inpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
• Rehabilitation – Outpatient		COVERAGE PROVIDED UNDER A SEPARATE BEHAVORIAL HEALTH PROGRAM OFFERED BY LEHIGH UNIVERSITY
Home Health Care Services	100 visits/benefit period	Covered in full
Durable Medical Equipment (DME)		Covered in full
Prosthetic Appliances		Covered in full
Orthotic Devices		Covered in full

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Managed Behavioral Health in PPO100 and Keystone

Benefit Plan Summary for PPO100

Service	IBH Network	Non-Network	Pre-Certification
Inpatient Psychiatric Care	**100%**	▪ 80% of IBH allowable after $500 deductible (combined MH, CD, and medical) .	**Required through IBH for both network and non-network** 50% penalty for services provided by non-network providers w/o pre-authorization.
Mental Health (MH)- Outpatient Office Visits –Individual, Family, Group Counseling	**$20 co-pay**	▪ 80% of IBH allowable after $500 deductible (combined MH, CD, and medical) .	**Some services require Pre-Certification.**
Inpatient Chemical Dependence (CD)/Substance Abuse	**100%**	▪ 80% of IBH allowable after $500 deductible (combined MH, CD, and medical) .	**Required through IBH for both network and non-network** 50% penalty for services provided by non-network providers w/o pre-authorization.
Chemical Dependence (CD)/ Substance Abuse - Outpatient Office Visits – Individual, Family, Group Counseling	**$20 co-pay**	▪ 80% of IBH allowable after $500 deductible (combined MH, CD, and medical) .	**Some services require Pre-Certification.**

- **Treatment must be provided by a psychiatrist, psychologist, therapist or clinical social worker who is licensed to practice independently at the master's level or above.**
- **Laboratory work must be prescribed by a psychiatrist.**
- **Treatment must be delivered in a goal-oriented manner that produces observable and measurable improvement in the patient's condition.**

Benefit Plan Summary for Keystone Health Plan

Service	IBH Network	Non-Network	Pre-Certification
Inpatient Psychiatric Care	**100%**	No benefit	**Required through IBH**
Mental Health (MH)- Outpatient Office Visits –Individual, Family, Group Counseling	**$20 co-pay**	No benefit	**Some services require Pre-Certification.**
Inpatient Chemical Dependence (CD)/Substance Abuse	**100%**	No benefit	**Required through IBH**
Chemical Dependence (CD)/Substance Abuse - Outpatient Office Visits – Individual, Family, Group Counseling	**$20 co-pay**	No benefit	**Some services require Pre-Certification.**

- **Only inpatient services pre-certified by IBH and provided by network providers are covered. There is no benefit for non-network providers or for services not pre-certified.**
- **Treatment must be provided by a psychiatrist, psychologist, therapist or clinical social worker who is licensed to practice independently at the master's level or above.**
- **Laboratory work must be prescribed by a psychiatrist.**
- **Treatment must be delivered in a goal-oriented manner that produces observable and measurable improvement in the patient's condition.**

A Managed Behavioral Health Plan includes mental health and substance abuse treatment benefits. The behavioral health benefit included for this plan is provided by Integrated Behavioral Health (IBH). This plan is compliant with the Mental Health Parity and Equity Act of 2008 (MHPAEA) and Final Rules of 2013.

Plan features include:

- Use of IBH network providers results in lower copays, coinsurance and patient financial responsibility.
- National network of quality providers and facilities selected and credentialed by IBH.
- No need for patient submission of claim forms when IBH network providers are used.
- IBH network providers accept the plan payment as payment in full after the applicable copayment or deductible.
- All mental health services are subject to evidentiary standards of care and medical necessity.
- Some services require prior authorization, call IBH for care coordination.
- If treatment is needed call 800-395-1616 and IBH will provide referrals, case management, care coordination, and benefit questions for your behavioral health plan.

Certain services are still required to be pre-authorized; contact IBH with any questions.

Pre-authorization of all behavioral health services including initial outpatient care with a psychiatrist, psychologist or therapist is highly recommended. Pre-authorization of behavioral health services will insure medical necessity criteria are met and retrospective review will be limited. All care is subject to eligibility, plan definitions, limitations, exclusions, and are payable when determined by IBH as medically necessary and appropriate.

Inpatient and Program based Mental Health Benefits:

To find an in-network facility, contact Integrated Behavioral Health at 800-395-1616. The benefit may allow you to choose services through an out-of-network facility, but you may have to pay a larger portion of the costs, and subject to prior authorization and concurrent review.

Pre-authorization is required for all inpatient, partial hospitalization, residential, and any program based care. You or your provider may call an IBH care manager at 800-395-1616 to obtain preauthorization prior to starting any intensive treatment program.

Outpatient Mental Health Benefits:

All outpatient care falling within outlier categories, requires the provider to submit documentation for review of medical necessity, evidentiary based treatment, and appropriateness of care.

The following outpatient evaluations or treatments require authorization before commencing:

- Psychological testing
- Group therapy

- Outpatient Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Or any service determined as an outlier.

The benefit may allow you to choose services through either an IBH network provider or a non-network provider. Non-network providers must be independently licensed and still must follow plan requirements of submitting documentation of evidentiary standards and medically necessary care. Call IBH to determine if a non-network provider is eligible for coverage under your plan.

While there are no treatment visit or hospital day limits in the benefit plan, all claims for treatment (including those delivered before any pre-authorization) are subject to review for medical necessity and appropriateness of care by IBH.

All claims are subject to benefit eligibility as well as plan exclusions and limitations at time of service.

Services Not Included in the Managed Behavioral Health Plan in PPO100 or Keystone HMO:

1. Services performed by the patient on him/herself or performed by immediate family, or an individual residing in the same household, including but not limited to a spouse, child, brother, sister, parent, or the spouse's parent, even if that individual is a qualified provider.
2. Services provided by someone not licensed by the state to treat the condition for which the claim is made and to independently bill fee for service and/or not trained or experienced to treat a specific condition under review.
3. Extended hospital, residential or program related stays that are unrelated to medically necessary and approved treatment.
4. Services furnished by or for the U.S. government, Federal and state funded agency or foreign government, unless payment is legally required.
5. Treatment that is of an experimental or educational nature. Procedures which are experimental, investigational, or unproven. Therapies and technologies whose long-term efficacy or effect is undetermined, or whose efficacy is no greater than that of traditionally accepted standard treatment.
6. Services applied under any government or publicly funded program or law under which the individual is covered.
7. Services for which a third-party is liable.
8. New procedures, services, and medication until they are reviewed for safety and efficacy, through accepted evidentiary review.
9. Services that are primarily to assess or address neurodevelopmental disorders are to be considered as medical conditions and as such not covered under the mental health benefits. With the exception of Attention Deficit/ Hyperactivity disorder, and Tic disorders which are covered by the mental health portion of the plan.
10. Custodial care or supportive counseling, including care for conditions not typically resolved by treatment.
11. Alternative treatment methods that do not meet national standards for behavioral

health practice, including but not limited to: regressive therapy, aversion therapy, neurofeedback or neuro-biofeedback, hypnotherapy, acupuncture, acupressure, aromatherapy, massage therapy, reiki, thought-field energy, art or dance therapy.

12. Services not medically necessary. All services must be medically necessary. The fact that a physician or other provider may prescribe, order, recommended, or approve a service or supply does not, in itself, make it medically necessary, even though it is not specifically listed as an exclusion or limitation.

13. Court-ordered treatment. If a participant is currently in a course of treatment that is confirmed as being required by a court, the treatment may be considered only as long as it is medically necessary.

14. Psychological or neuropsychological testing, unless specifically pre-certified by IBH.

15. Inpatient treatment for co-dependency, gambling and sexual addiction.

16. Treatment primarily for chronic pain management or neuropsychological rehabilitation.

17. Treatment primarily for the convenience of the patient or provider.

18. Treatment provided primarily for medical or other research.

19. Charges for services, supplies or treatments which are primarily educational in nature; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

20. Charges primarily for marriage, career, or legal counseling, mediation, or custody related services.

21. Treatment of sexual dysfunction not related to organic disease. Sex therapy.

22. Services provided if covered individual would not legally have to pay for them if the covered individual were not covered by the Plan or any other medical plan, to the extent that exclusion of charges for such services is not prohibited by law or regulation.

23. Assessment or treatment related to sex change procedures.

24. Evaluation or services not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.

25. Charges for obtaining medical records or completing a treatment report, and late payment charges.

26. Methadone maintenance.

27. Speech and language evaluations or speech therapy.

28. Charges for failure to keep a scheduled visit, charges for completion of a claim form.

29. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.

30. Expenses for pastoral counseling, marriage therapy, music or art therapy, assertiveness training, social skills training, recreational therapy, stress management, or other supportive therapies.

31. Long-term treatment at a residential treatment facility, or long term rehabilitation therapy.

32. Smoking cessation programs not covered under the medical plan.

33. Therapeutic foster care, group home, halfway or three-quarter houses, residential/therapeutic schools, camps.

34. Any treatment or condition excluded by
the medical Plan.

How Managed Behavioral Health Plan Claims Are Paid:
Network services require no claim forms. IBH will pay your provider directly. You are responsible for paying coinsurance, copay, or deductible that may apply.

If you use a non-network provider, either you or the provider must submit a claim form and you are responsible for paying the balance of the provider's outpatient or inpatient mental health or substance abuse charges, after the IBH payment of the non-network benefit based on the IBH allowable rate. The IBH allowable rate is the rate for the IBH fee schedule for specific network services. Remember if you use non-network providers, your financial responsibility, the amount you pay, for non-network mental health or substance abuse care is higher and is based on the IBH allowable rate. Claims may be mailed to:

Integrated Behavioral Health
Claims Department
P.O. 30018
Laguna Niguel, CA 92607-0018

How to File a Managed Behavioral Health Plan Appeal:
For purposes of the appeal procedure, a mental health or substance abuse claim appeal includes any request for benefits or authorization that is denied either in part or in whole. You or your provider may appeal a claim or other adverse benefit decision directly to IBH. The appeal must be submitted to:

Integrated Behavioral Health
Quality Management—Appeals
P.O. Box 30018
Laguna Niguel, CA 92607-0018

Appeals Process:

Policy: Integrated Behavioral Health shall offer an appeals process for both members and providers. Such policy shall include reasonable efforts to resolve concerns and disagreements prior to a formal appeal process through collegial and non-adversarial means. The appeals process is consistent with ERISA guidelines.

Procedures: IBH provides an appeal process for members, providers and employers/health plans hereinafter referred to as claimant. This appeal process is available for any adverse benefit decision and/or when disagreements occur regarding decisions or potential decisions about authorizations for proposed treatment, claims payments, or treatment reviews. When such adverse benefit decisions or disagreements occur, the member, provider or employer/health plan may request reconsideration by phone or mail. A Senior Care Manager or supervisor

responds to this Request for Reconsideration immediately. The response is communicated by phone and mail. Facsimile is used when issues are urgent.

Should this reconsideration process fail to satisfy the issue, the claimant may submit a formal appeal for review. This Level 1 Appeal may be a written request or telephonic. It is responded to within the timeframes outlined below for the particular type of claim. A clinical person, with appropriate expertise, and other than the care manager who effected the denial must conduct the appeal review. Such clinician may not be supervised by the initial reviewer. The response is communicated by phone and mail. Facsimile is used when issues are urgent.

External Review Option: If the appealing party continues to be dissatisfied, a second level appeal can be requested in writing or telephonically and is conducted by an external clinical person with appropriate expertise. This decision is also provided within the timeframes outlined below for the particular type of claim. The providers and members are informed by mail or facsimile, depending on the urgency.

All protected health information shall be managed within HIPAA regulations and within other federal law and regulations specific to confidentiality of behavioral health medical data.

Timeframes:

Expedited/Urgent Care Claims

Initial Claim Response Timeframe:	48 Hours
Request Missing Info from Claimant:	24 Hours
Claimant to Provide Missing Info:	48 Hours
Claimant to Request Appeal:	180 days
Appeal Response Timeframe:	72 Hours

Pre-Service Health Care Claims

Initial Claim Response Timeframe:	15 Days
Extension (Proper Notice/Delay Beyond Plan Control):	15 Days
Request Missing Info from Claimant:	5 Days
Claimant to Provide Missing Info:	50 Days
Claimant to Request Appeal:	180 Days
Appeal Response Timeframe:	30 Days

Post-Service Health Care Claim

Initial Claim Response Timeframe:	30 Days
Extension (Proper Notice/Delay Beyond Plan Control):	15 Days
Request Missing Info from Claimant:	30 Days
Claimant to Provide Missing Info:	50 Days
Claimant to Request Appeal:	180 Days

Appeal Response Timeframe: 60 Days

Additional Claimant Rights:

The claimant is entitled to receive, free of charge, and have access to all relevant documents and information relied upon in making the claim determination.

Once you have completed all mandatory appeals, you and your plan may have other voluntary alternative dispute resolution options. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Under ERISA Section 502(a)(I)(B), you have the right to bring a civil action. This right can be exercised when all required reviews of your claims, including the appeal process, have been completed, your claim was not approved, in whole or in part, and you disagree with the outcome.

The above-described Appeal Process is subject to all applicable State and Federal laws and regulations.

This information highlights the preventive care services available under this *coverage*. It is not intended to be a complete list or complete description of available services. Services may be subject to *copayment*, *deductible* and/or *coinsurance*. Additional diagnostic studies may be covered if *medically necessary* for a particular diagnosis or procedure. Members may refer to the benefit contract for specific information on available *benefits or contact Customer Service at the number listed on their ID card.*

SERVICE	RECOMMENDED AGES/FREQUENCY *

Routine History and Physical Examination – Initial/Interval
Exams should include:
• Newborn screening (including gonorrhea prophylactic topical eye medication and hearing loss)
• Head circumference (up to 24 months)
• Height/length and weight
• Body mass index (BMI; beginning at 2 years of age)
• Blood pressure (beginning at 3 years of age)
• Sensory screening for vision and hearing
• Developmental milestones (screening/surveillance)
• Iron supplementation (6 to 12 months) at increased risk for iron deficiency anemia***
• Autism screening (18 + 24 months)
• STD screening (males/females, as appropriate)
• Anticipatory guidance for age-appropriate issues including:
  • Growth and development, breastfeeding/nutrition, obesity prevention, physical activity and psychosocial/behavioral health
  • Safety, unintentional injuries, firearms, poisoning, media access
  • Pregnancy prevention
  • Tobacco products
  • Dental care/fluoride supplementation (≥ 6 months)[3]
  • Fluoride varnish painting of primary teeth (to age 5 years)
  • Sun/UV radiation skin exposure
	Newborn, 3-5 days, by 1 month, 2 months,
	4 months, 6 months, 9 months,
	12 months, 15 months,
	18 months, 24 months, 30 months,
	3 years to 18 years annually

SCREENINGS	RECOMMENDED AGES/FREQUENCY */**
Newborn screen (including hypothyroidism, sickle cell disease and PKU)	At birth
Lead screening	9-12 months (at risk)[1]
Hemoglobin and Hematocrit	At 12 months: routine one-time testing Assess risk at all other well child visits
Urinalysis	5 years (at risk)
Lipid screening (risk assessment)	Every 2 years, starting at 2 years -- 2, 4, 6, 8 and 10 years Annually, starting at 11 years
Fasting Lipid Profile	Routinely, at 18 years (younger if risk assessed as high)
Tuberculin test	Assess risk at every well child visit
Vision test (objective method)	Beginning at 3 years: annually
Hearing test (objective method)	At birth and at 4, 5, 6, 8 and 10 years
Depression screening (PHQ-2)	Beginning at 11 years: annually
Alcohol and drug use assessment (CRAFFT)	Beginning at 11 years: annually
STI/HIV screening	Beginning at 11 years: annually
Syphilis test (males/females)	18 years and younger (high risk males/females***): suggested testing interval is 1-3 years
HIV test (males/females)	Age 15-18: routine one-time testing Regardless of age: repeat testing of all high risk persons;*** suggested testing interval is 1–5 years
Chlamydia test (females)	18 years and younger (sexually active females as well as other asymptomatic females at increased risk*** for infection): annually
Gonorrhea test (females)	18 years and younger (high risk sexually active females***): suggested testing interval is 1-3 years.

IMMUNIZATIONS	RECOMMENDED AGES/FREQUENCY */**
Rotavirus (RV)	2 months, 4 months, or 6 months for specific vaccines
Polio (IPV)	2 months, 4 months, 6–18 months, 4–6 years
Diphtheria/Tetanus/Pertussis (DTaP)	2 months, 4 months, 6 months, 15–18 months, 4–6 years
Tetanus/reduced Diphtheria/Pertussis (Tdap)	11–12 years (catch-up through age 18)
Human papillomavirus (HPV2/HPV4 -- females); (HPV4 -- males)	11--12 years (3 doses) (catch-up through age 18)
Measles/Mumps/Rubella (MMR)	12–15 months, 4-6 years (catch-up through age 18)
Hemophilus influenza type b (Hib)	2 months, 4 months, 6 months for specific vaccines & 12-15 months
Varicella/Chickenpox (VAR)	12-15 months, 4-6 years (catch-up through age 18)
Hepatitis A (HepA)	12--23 months (2 doses) (catch-up through age 18)
Influenza	6 months-18 years; annually[2] during flu season
Pneumococcal conjugate (PCV13)	2 months, 4 months, 6 months, 12–15 months
Pneumococcal polysaccharide (PPSV23)	2-18 years (1 or 2 doses) [high risk: see CDC]
Hepatitis B (HepB)	Birth, 1–2 months, 6–18 months (catch-up through age 18)
Meningococcal (MenACWY-D/MenACWY-CRM) [high risk: see CDC]	11--12 years, 16 years (catch-up through age 18)

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This preventive schedule is periodically updated to reflect current recommendations from the American Academy of Pediatrics (AAP), U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices (ACIP), Centers for Disease Control and Prevention (CDC) [www.cdc.gov].

This schedule includes the services deemed to be mandated under the federal Patient Protection and Affordable Care Act (PPACA). As changes are communicated, Capital BlueCross will adjust the preventive schedule as required.

Sections footnotes:

*Services that need to be performed more frequently than stated due to specific health needs of the Member and that would be considered medically necessary may be eligible for coverage when submitted with the appropriate diagnosis and procedure(s) and are covered under the core medical benefit.

**Capital BlueCross considers Members to be “high risk” or “at risk” in accordance with the guidelines set forth by the Centers for Disease Control and Prevention (CDC).

***Capital BlueCross considers individuals to be “high risk” or “at risk” in accordance with the recommendations set forth by the U.S. Preventive Services Task Force (USPSTF)[www.ahrq.gov/clinic/uspstfix.htm]

Screening/Immunizations footnotes:

[1] Encourage all PA-CHIP Members to undergo blood lead level testing before age 2 years.

[2] Children aged 8 years and younger who are receiving influenza vaccines for the first time should receive 2 separate doses, both of which are covered. Household contacts and out-of-home caregivers of a high risk Member, including a child aged 0-59 months, should be immunized against influenza.

[3] Fluoride supplementation pertains only to children who reside in communities with inadequate water fluoride.

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Schedule of Preventive Care Services
Adult Preventive Health Maintenance Guidelines

This information highlights the preventive care services available under this *coverage*. It is not intended to be a complete list or complete description of available services. Services may be subject to *copayment*, *deductible* and/or *coinsurance*. Additional diagnostic studies may be covered if *medically necessary* for a particular diagnosis or procedure. *Members* may refer to the benefit contract for specific information on available *benefits* or contact Customer Service at the number listed on their ID card.

SERVICE	RECOMMENDED AGES/FREQUENCY *
Routine History and Physical Examination, including BMI and pertinent patient education *Adult counseling and patient education include:*	WOMEN --19+: at least annually MEN -- 19–29: once 30–49: every 4 years 50+: annually
Women • Folic Acid (childbearing age) • Contraceptive methods/counseling • Mammography screening • HRT (risk vs. benefits) • Breast Cancer chemoprevention (high risk)*** • Breastfeeding support/counseling/supplies	
Men • Prostate Cancer screening	
For Both • Tobacco use • STIs • Seat Belt use • Aspirin prophylaxis (high risk) *** • Physical Activity • Drug and Alcohol use • Unintentional Injuries • Family Planning • Sun/UV skin radiation • Depression • Calcium/vitamin D intake • Fall Prevention • Domestic/Interpersonal Violence	

SCREENINGS	RECOMMENDED AGES/FREQUENCY*/**
Obesity/Healthy diet screening/counseling	Age 19 and older (high risk);*** every year
Pelvic Exam/Pap Smear [USPSTF cytology option][5]	Age 21–29; every 3 years
Pelvic Exam/Pap Smear [USPSTF cytology option][5]	Age 30–65; every 3 years
Pelvic Exam/Pap Smear/HPV DNA [USPSTF co-testing option][5]	Age 30–65; every 5 years
Pelvic Exam/HPV DNA (women) [IOM option][5]	Beginning at 30; every 3 years
Chlamydia Test (women)	Age 19-24: Test all sexually active females; annually Age 25 and older: Test all females at increased risk; *** suggested testing interval is 1–3 years
Gonorrhea Test (women)	Age 19 and older: Test all high risk sexually active females;*** suggested testing interval is 1-3 years.
Syphilis Test (men/women)	Age 19 and older: Test all high risk men/women; *** suggested testing interval is 1–3 years
HIV Test (men/women)	Age 19-65: Routine one-time testing of persons not known to be at increased risk for HIV infection Age 19 and older: Repeat testing all high risk persons; *** suggested testing interval is 1–5 years
Hepatitis C Test	Offer one-time testing of adults born between 1945 and 1965 Periodic testing of persons with *continued high risk*** for HCV infection
Blood Pressure	Age 19 and older: every 2 years (general ≥ 60: < 150/90; general < 60 and all others: < 140/90)
Diabetes Screening Test (type 2)	Beginning at 19; test asymptomatic adults with sustained BP > 135/80 every 3 years
Fasting Lipid Profile	Beginning at 20; every 5 years
Fecal Occult Blood Test[1]	Beginning at 50; annually
Flexible Sigmoidoscopy[2]	Beginning at 50; every 5 years
Colonoscopy[2]	Beginning at 50; every 10 years
Barium Enema X-ray[3]	Beginning at 50; every 5 years
Prostate Specific Antigen	Offer beginning at 50 and annually thereafter
Low-dose CT Scan	Age 55-80 (high risk): *** Annual testing until smoke-free for 15 years.
Abdominal Ultrasound (men)	Age 65–75: one-time screening for abdominal aortic aneurysm in men who have ever smoked
BRCA screening/counseling/testing [as needed]	Beginning at 19 (high risk women); *** reassess screening every 5-10 years
Mammogram	Beginning at 40; every 1-2 years
Bone Mineral Density (BMD) Testing (women)	Age 19–64: testing every 2 years may be appropriate for women at high risk. *** Beginning at 65; every 2 years

IMMUNIZATIONS	RECOMMENDED AGES/FREQUENCY*/**
Tetanus/diphtheria/pertussis (Td/Tdap)	19+; Td every 10 years (substitute one dose of Tdap for Td, regardless of interval since last booster)
Human papillomavirus (HPV2/HPV4 -- women); (HPV4 -- men)	19–26; three doses, if not previously immunized (for men 22-26, see CDC)
Hepatitis A (HepA)	19+; two doses (high risk; see CDC)
Hepatitis B (HepB)	19+; three doses (high risk; see CDC)
Hemophilus influenza type b (Hib)	19+; one or three doses (high risk; see CDC)
Influenza[4]	19+; one dose annually during influenza season
Meningococcal (MCV4/MPSV4)	19+; one or more doses: (college students and others at high risk not previously immunized; see CDC)
Pneumococcal (conjugate) (PCV13)	19+; one dose (high risk; see CDC)
Pneumococcal (polysaccharide) (PPSV23)	19–64; one or two doses (high risk; see CDC) Beginning at 65; one dose (regardless of previous PPSV23 immunization; see CDC)
Measles/Mumps/Rubella (MMR)	19-54; one or two doses, give as necessary based upon past immunization history 55+; one or two doses (high risk; see CDC)
Varicella (Chickenpox)	Beginning at 19; two doses, give as necessary based upon past immunization or medical history
Zoster (Shingles)	Beginning at 50; one dose, regardless of prior zoster episodes (see CDC)

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This preventive schedule is periodically updated to reflect current recommendations from the U.S. Preventive Services Task Force (USPSTF); National Institutes of Health (NIH); NIH Consensus Development Conference Statement, March 27–29, 2000; Advisory Committee on Immunization Practices (ACIP); Centers for Disease Control and Prevention (CDC); American Diabetes Association (ADA); American Cancer Society (ACS); Eighth Joint National Committee (JNC 8); Institute of Medicine (IOM); U.S. Food and Drug Administration (FDA).

This schedule includes the services deemed to be mandated under the federal Patient Protection and Affordable Care Act (PPACA). As changes are communicated, Capital BlueCross will adjust the preventive schedule as required.

Sections footnotes:

* Services that need to be performed more frequently than stated due to specific health needs of the member and that would be considered medically necessary may be eligible for coverage when submitted with the appropriate diagnosis and procedure(s) and are covered under the core medical benefit. Occupational, school and other "administrative" exams are not covered.

**Capital BlueCross considers individuals to be "high risk" or "at risk" in accordance with the guidelines set forth by the Centers for Disease Control and Prevention (CDC) [www.cdc.gov]

***Capital BlueCross considers individuals to be "high risk" or "at risk" in accordance with the recommendations set forth by the U.S. Preventive Services Task Force USPSTF) [www.ahrq.gov/clinic/uspstfix.htm]

Screenings/Immunizations footnotes:

[1]For guaiac-based testing, six stool samples are obtained (2 samples on each of 3 consecutive stools, while on appropriate diet, collected at home). For immunoassay testing, specific manufacturer's instructions are followed.

[2]Only one endoscopic procedure is covered at a time, without overlap of the recommended schedules.

[3]Barium enema is listed as an alternative to a flexible sigmoidoscopy, with the same schedule overlap prohibition as found in footnote #2.

[4]Capital BlueCross has extended coverage of influenza immunization to all individuals with the preventive benefit regardless of risk.

[5]Recommendations of both the USPSTF and the IOM are included in order to aid clinicians in counseling their patients about preferred or acceptable preventive strategies. It should be noted that screening for cervical cancer should not be the sole health care concern when conducting ongoing well-woman visits.

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SERVICES REQUIRING PREAUTHORIZATION

Members should present their *identification card* to their health care *provider* when medical services or items are requested. When *members* use a *participating provider* (including a BlueCard facility *participating provider* providing ***inpatient*** **services**), the *participating provider* will be responsible for obtaining the *preauthorization*. If *members* use a *non-participating provider* or a BlueCard *participating provider* providing ***non-inpatient*** **services**, the *non-participating provider* or BlueCard *participating provider* may call for *preauthorization* on the *member's* behalf; however, it is ultimately the *member's* responsibility to obtain *preauthorization*. *Providers* and *members* should call *Capital's* Clinical Management Department toll-free at **1-800-471-2242** to obtain the necessary *preauthorization*.

Providers/Members should request Preauthorization of non-urgent admissions and services well in advance of the scheduled date of service (15 days). *Investigational* or experimental procedures are not usually covered benefits. *Members* should consult their *Certificate of Coverage, Capital BlueCross' Medical Policies,* or contact Customer Service at the number listed on the back of their health plan identification card to confirm *coverage*. *Participating providers* and Members have full access to *Capital's* medical policies and may request *preauthorization* for experimental or *investigational* services/items if there are unique *member* circumstances.

Capital only pays for services and items that are considered *medically necessary*. *Providers* and *members* can reference *Capital's* medical policies for questions regarding *medical necessity*.

PREAUTHORIZATION OF MEDICAL SERVICES INVOLVING URGENT CARE

If the *member's* request for *preauthorization* involves *urgent care*, the *member* or the *member's provider* should advise *Capital* of the urgent medical circumstances when the *member* or the *member's provider* submits the request to *Capital's* Clinical Management Department. *Capital* will respond to the *member* and the *member's provider* no later than seventy-two (72) hours after *Capital's* Clinical Management Department receives the *preauthorization* request.

PREAUTHORIZATION PENALTY APPLICABILITY

Failure to obtain *preauthorization* for a service could result in a payment reduction or denial for the *provider* and *benefit* reduction or denial for the *member*, based on the *provider's* contract and the *member's* Certificate of Coverage. Services or items provided without *preauthorization* may also be subject to retrospective *medical necessity* review.

If the *member* presents his/her *ID card* to a *participating provider* in the 21-county area and the *participating provider* fails to obtain or follow *preauthorization* requirements, payment for services will be denied and the provider may not bill the member.

When *members* undergo a procedure requiring *preauthorization* and fail to obtain *preauthorization* (when responsible to do so), *benefits* will be provided for *medically necessary* covered services. However, in this instance, the *allowable amount* may be reduced by the dollar amount or the percentage established in the *Certificate of Coverage.*

The table that follows is a partial listing of the *preauthorization* requirements for services and procedures.

Category	Details	Comments
Inpatient Admissions	• Observation care admissions • Acute care • Long-term acute care • Non-routine maternity admissions • Skilled nursing facilities • Rehabilitation hospitals • Behavioral Health (mental health care/ substance abuse) includes partial hospitalization & intensive outpatient programs	Emergent/Urgent admissions to observation or inpatient status require notification within two (2) business days. All such services will be reviewed and must meet medical necessity criteria from the first hour of admission. Failure to notify Capital BlueCross of an admission may result in an administrative denial. Non-routine maternity admissions require notification within two (2) business days of the date of admission. *Preauthorization* requirements do not apply to services provided by a *hospital* emergency room *provider*. If an *inpatient* admission or observation admission results from an emergency room visit, notification must occur within two (2) business days of the admission. If the *hospital* is a *participating provider*, the hospital is responsible for performing the notification. If the *hospital* is a *non-participating provider and is not BlueCard*, the *member* or the *member's* responsible party acting on the *member's* behalf is responsible for the notification
Diagnostic Services	• Genetic disorder testing **except**: standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn genetic testing • Cardiac nuclear medicine studies including nuclear cardiac stress tests • CT (computerized tomography) scans • MRA (magnetic resonance angiography) • MRI (magnetic resonance imaging), • PET (positron emission tomography) scans • SPECT (single proton emission computerized tomography) scans	Diagnostic services do not require *preauthorization* when emergently performed during an emergency room visit, observation stay, or *inpatient* admission.
Durable Medical Equipment (DME), Prosthetic Appliances & Orthotic Devices	Purchases and Repairs greater than or equal to $500 Rentals for DME regardless of price per unit	
Office Surgical Procedures When Performed in a Facility*	• Aspiration and/or injection of a joint • Colposcopy • Treatment of warts • Excision of a cyst of the eyelid (chalazion) • Excision of a nail (partial or complete) • Excision of external thrombosed hemorrhoids; • Injection of a ligament or tendon; • Eye injections (intraocular) • Oral Surgery • Pain management (including facet joint injections, trigger point injections, stellate ganglion blocks, peripheral nerve blocks, SI joint injections, and intercostals nerve blocks) • Proctosigmoidoscopy/flexible Sigmoidoscopy; • Removal of partial or complete bony impacted teeth (if a benefit); • Repair of lacerations, including suturing (2.5 cm or less); • Vasectomy • Wound care and dressings (including outpatient burn care)	The items listed are those items or services most frequently requested. This list is not all inclusive. Depending on whether the *provider* is participating or non-participating, *members* or their *provider* must contact *Capital* to confirm if items or services not listed here require *preauthorization*.

Category	Details	Comments
Outpatient Surgery for Select Procedures	• Weight loss surgery (Bariatric) • Implantation electrical nerve stimulator • Meniscal transplants, allografts and collagen meniscus implants (knee) • Ovarian and Iliac Vein Embolization • Photodynamic therapy • Radioembolization for primary and metastatic tumors of the liver • Radiofrequency ablation of tumors • Transcatheter aortic valve replacement • Valvuloplasty	The items listed are those items or services most frequently requested. This list is not all inclusive. Depending on whether the *provider* is participating or non-participating, *members* or their *provider* must contact *Capital* to confirm if items or services not listed here require *preauthorization*.
Therapy Services	• Hyperbaric oxygen therapy (non-emergency) • Manipulation therapy (chiropractic and osteopathic) • Occupational therapy • Physical therapy • Pulmonary rehabilitation programs • Respiratory Therapy • Radiation therapy and related treatment planning and procedures performed for planning (such as but not limited to IMRT, proton beam, neutron beam, brachytherapy, 3D conform, SRS, SBRT, Gamma knife, EBRT, IORT, IGRT)	
Reconstructive or Cosmetic Services and Items	Removal of excess fat tissue (Abdominoplasty/Panniculectomy and other removal of fat tissue such as Suction Assisted Lipectomy) Breast Procedures • Breast Enhancement (Augmentation) • Breast Reduction • Mastectomy (Breast removal or reduction) for Gynecomastia • Breast Lift (Mastopexy) • Removal of Breast implants Correction of protruding ears (Otoplasty) Repair of nasal/septal defects (Rhinoplasty/Septoplasty) Skin related procedures • Acne surgery • Dermabrasion • Destruction of premalignant skin cells • Hair removal (Electrolysis/Epilation) • Face Lift (Rhytidectomy) • Removal of excess tissue around the eyes (Blepharoplasty/Brow Ptosis Repair) • Mohs Surgery Treatment of Varicose Veins and Venous Insufficiency	The items listed are those items or services most frequently requested. This list is not all inclusive. Depending on whether the *provider* is participating or non-participating, *members* or their *provider* must contact *Capital* to confirm if items or services not listed here require *preauthorization*.
Transplant Surgeries	Evaluation and services related to transplants	*Preauthorization* will include referral assistance to the Blue Distinction Centers for Transplant network if appropriate.

Category	Details	Comments
Other Services	• Bio-engineered skin or biological wound care products • Category IDE trials (Investigational Device Exemption) • Clinical trials (including cancer related trials) • Enhanced external counterpulsation (EECP) • Home health care • Home infusion therapy • Eye injections (Intravitreal angiogenesis inhibitors) • Laser treatment of skin lesions • Non-emergency air and ground ambulance transports • Radiofrequency ablation for pain management • Facility based sleep studies for diagnosis and medical Management of obstructive sleep apnea • Specialty medical injectable medications • Enteral feeding supplies and services.	

PLEASE NOTE: This listing identifies those services that require *preauthorization* only as of the date it was printed. This listing is subject to change. *Members* should call *Capital* at 1-800-962-2242 (TTY: 711) with questions regarding the *preauthorization* of a particular service.

This information highlights the standard Preauthorization Program. *Members* should refer to their *Certificate of Coverage* for the specific terms, conditions, exclusions and limitations relating to their *coverage*.

SERVICES REQUIRING PREAUTHORIZATION

Members should present their *identification card* to their health care *provider* when medical services or items are requested. When *members* use a *participating provider* (including a BlueCard facility *participating provider* providing ***inpatient*** **services**), the *participating provider* will be responsible for obtaining the *preauthorization*. If *members* use a *non-participating provider* or a BlueCard *participating provider* providing ***non-inpatient*** **services**, the *non-participating provider* or BlueCard *participating provider* may call for *preauthorization* on the *member's* behalf; however, it is ultimately the *member's* responsibility to obtain *preauthorization*. *Providers* and *members* should call *Keystone Health Plan Central's* Clinical Management Department toll-free at **1-800-471-2242** to obtain the necessary *preauthorization*.

Providers/Members should request Preauthorization of non-urgent admissions and services well in advance of the scheduled date of service (15 days). *Investigational* or experimental procedures are not usually covered benefits. *Members* should consult their *Certificate of Coverage, Keystone Health Plan Central's* medical policies, or contact Customer Service at the number listed on the back of their health plan identification card to confirm *coverage*. *Participating providers* and *members* have full access to *Keystone Health Plan Central's* medical policies and may request *preauthorization* for experimental or *investigational* services/items if there are unique *member* circumstances.

Keystone Health Plan Central only pays for services and items that are considered *medically necessary*. *Providers* and *members* can reference *Keystone Health Plan Central's* medical policies for questions regarding *medical necessity*.

PREAUTHORIZATION OF MEDICAL SERVICES INVOLVING URGENT CARE

If the *member's* request for *preauthorization* involves *urgent care*, the *member* or the *member's provider* should advise *Keystone Health Plan Central* of the urgent medical circumstances when the *member* or the *member's provider* submits the request to *Keystone Health Plan Central's* Clinical Management Department. *Keystone Health Plan Central* will respond to the *member* and the *member's provider* no later than seventy-two (72) hours after *Keystone Health Plan Central's* Clinical Management Department receives the *preauthorization* request.

PREAUTHORIZATION PENALTY APPLICABILITY

Failure to obtain *preauthorization* for a service could result in a payment reduction or denial for the *provider* and *benefit* reduction or denial for the *member*, based on the *provider's* contract and the *member's* Certificate of Coverage. Services or items provided without *preauthorization* may also be subject to retrospective *medical necessity* review.

If the *member* presents his/her *ID card* to a *participating provider* in the 21-county area and the *participating provider* fails to obtain or follow *preauthorization* requirements, payment for services will be denied and the provider may not bill the member.

When *members* undergo a procedure requiring *preauthorization* and fail to obtain *preauthorization* (when responsible to do so), *benefits* will be provided for *medically necessary* covered services. However, in this instance, the *allowable amount* may be reduced by the dollar amount or the percentage established in the *Certificate of Coverage.*

The table that follows is a partial listing of the *preauthorization* requirements for services and procedures.

Category	Details	Comments
Inpatient Admissions	• Observation care admissions • Acute care • Long-term acute care • Non-routine maternity admissions • Skilled nursing facilities • Rehabilitation hospitals • Behavioral Health (mental health care/ substance abuse) includes partial hospitalization & intensive outpatient programs	Emergent/Urgent admissions to observation or inpatient status require notification within two (2) business days. All such services will be reviewed and must meet medical necessity criteria from the first hour of admission. Failure to notify *Keystone Health Plan Central* of an admission may result in an administrative denial. Non-routine maternity admissions require notification within two (2) business days of the date of admission. *Preauthorization* requirements do not apply to services provided by a *hospital* emergency room *provider*. If an *inpatient* admission or observation admission results from an emergency room visit, notification must occur within two (2) business days of the admission. If the *hospital* is a *participating provider*, the hospital is responsible for performing the notification. If the *hospital* is a *non-participating provider and is not BlueCard*, the *member* or the *member's* responsible party acting on the *member's* behalf is responsible for the notification
Diagnostic Services	• Genetic disorder testing except: standard chromosomal tests, such as Down Syndrome, Trisomy, and Fragile X, and state mandated newborn genetic testing • Cardiac nuclear medicine studies including nuclear cardiac stress tests • CT (computerized tomography) scans • MRA (magnetic resonance angiography) • MRI (magnetic resonance imaging), • PET (positron emission tomography) scans • SPECT (single proton emission computerized tomography) scans	Diagnostic services do not require *preauthorization* when emergently performed during an emergency room visit, observation stay, or *inpatient* admission.
Durable Medical Equipment (DME), Prosthetic Appliances & Orthotic Devices	Purchases and Repairs greater than or equal to $500 Rentals for DME regardless of price per unit	

Category	Details	Comments
Office Surgical Procedures When Performed in a Facility*	• Aspiration and/or injection of a joint • Colposcopy • Treatment of warts • Excision of a cyst of the eyelid (chalazion) • Excision of a nail (partial or complete) • Excision of external thrombosed hemorrhoids; • Injection of a ligament or tendon; • Eye injections (intraocular) • Oral Surgery • Pain management (including facet joint injections, trigger point injections, stellate ganglion blocks, peripheral nerve blocks, SI joint injections, and intercostals nerve blocks) • Proctosigmoidoscopy/flexible Sigmoidoscopy; • Removal of partial or complete bony impacted teeth (if a benefit); • Repair of lacerations, including suturing (2.5 cm or less); • Vasectomy • Wound care and dressings (including outpatient burn care)	The items listed are those items or services most frequently requested. This list is not all inclusive. Depending on whether the *provider* is participating or non-participating, *members* or their *provider* must contact *Keystone Health Plan Central* to confirm if items or services not listed here require *preauthorization*.
Outpatient Surgery for Select Procedures	• Weight loss surgery (Bariatric) • Implantation electrical nerve stimulator • Meniscal transplants, allografts and collagen meniscus implants (knee) • Ovarian and Iliac Vein Embolization • Photodynamic therapy • Radioembolization for primary and metastatic tumors of the liver • Radiofrequency ablation of tumors • Transcatheter aortic valve replacement • Valvuloplasty	The items listed are those items or services most frequently requested. This list is not all inclusive. Depending on whether the *provider* is participating or non-participating, *members* or their *provider* must contact *Keystone Health Plan Central* to confirm if items or services not listed here require *preauthorization*.
Therapy Services	• Hyperbaric oxygen therapy (non-emergency) • Manipulation therapy (chiropractic and osteopathic) • Occupational therapy • Physical therapy • Pulmonary rehabilitation programs • Respiratory Therapy • Radiation therapy and related treatment planning and procedures performed for planning (such as but not limited to IMRT, proton beam, neutron beam, brachytherapy, 3D conform, SRS, SBRT, Gamma knife, EBRT, IORT, IGRT)	

Category	Details	Comments
Reconstructive or Cosmetic Services and Items	Removal of excess fat tissue (Abdominoplasty/Panniculectomy and other removal of fat tissue such as Suction Assisted Lipectomy) Breast Procedures • Breast Enhancement (Augmentation) • Breast Reduction • Mastectomy (Breast removal or reduction) for Gynecomastia • Breast Lift (Mastopexy) • Removal of Breast implants Correction of protruding ears (Otoplasty) Repair of nasal/septal defects (Rhinoplasty/Septoplasty) Skin related procedures • Acne surgery • Dermabrasion • Destruction of premalignant skin cells • Hair removal (Electrolysis/Epilation) • Face Lift (Rhytidectomy) • Removal of excess tissue around the eyes (Blepharoplasty/Brow Ptosis Repair) • Mohs Surgery Treatment of Varicose Veins and Venous Insufficiency	The items listed are those items or services most frequently requested. This list is not all inclusive. Depending on whether the *provider* is participating or non-participating, *members* or their *provider* must contact *Keystone Health Plan Central* to confirm if items or services not listed here require *preauthorization*.
Transplant Surgeries	Evaluation and services related to transplants	*Preauthorization* will include referral assistance to the Blue Distinction Centers for Transplant network if appropriate.
Other Services	• Bio-engineered skin or biological wound care products • Category IDE trials (Investigational Device Exemption) • Clinical trials (including cancer related trials) • Enhanced external counterpulsation (EECP) • Home health care • Home infusion therapy • Eye injections (Intravitreal angiogenesis inhibitors) • Laser treatment of skin lesions • Non-emergency air and ground ambulance transports • Radiofrequency ablation for pain management • Facility based sleep studies for diagnosis and medical Management of obstructive sleep apnea • Specialty medical injectable medications • Enteral feeding supplies and services.	

PLEASE NOTE: This listing identifies those services that require *preauthorization* only as of the date it was printed. This listing is subject to change. *Members* should call *Keystone Health Plan Central* at 1-800-669-7075 (TTY: 711) with questions regarding the *preauthorization* of a particular service.

This information highlights the standard Preauthorization Program. *Members* should refer to their *Certificate of Coverage* for the specific terms, conditions, exclusions and limitations relating to their *coverage*.

Finding a Participating Provider for CMM Plan, PPO 80, PPO 100, and Keystone Health Plan Central

Go to http://www.capbluecross.com

Select *Find a Doctor or Facility* and on the next screen you can search for a doctor by name *or* by type or specialty.

Option One: Search by doctor's name

Enter the required information and select a medical plan:

For the CMM Plan, select: Comprehensive

For the PPO 80 and PPO 100, select: PPO (Capital Blue Cross and Federal Marketplace Plans)

For Keystone Health Plan Central, select: HMO (Capital Blue Cross and Federal Marketplace Plans)

Do not search for behavior health providers for PPO 100 or KHPC on this website. Integrated Behavioral Health (IBH) manages behavioral health services for these medical plans.

Option Two: Search by type or specialty

Enter the required information and select a medical plan:

For the CMM Plan, select: Comprehensive

For the PPO 80 and PPO 100, select: PPO (Capital Blue Cross and Federal Marketplace Plans)

For Keystone Health Plan Central, select: HMO (Capital Blue Cross and Federal Marketplace Plans).

When selecting the KHPC option, be sure to also check off the Primary Care Provider Only box if you are searching for a Primary Care Physician.

Do not search for behavior health providers for PPO 100 or KHPC on this website. Integrated Behavioral Health (IBH) manages behavioral health services for these medical plans.

Please remember:

If you are enrolling in Keystone Health Plan Central (KHPC), you will need to select a primary care physician and get their NPI/PCP number for your enrollment form.

Once you select your Primary Care Physician from the CBC website, you will need to click on the doctor's **View Profile** button to obtain their NPI/PCP number.

Here is information about Lehigh's contribution to the cost of the medical plans and your out-of-pocket costs for each of them in 2015.

Monthly Cost of Medical Coverage for 2015

2015 Monthly Cost	Lehigh Contribution	*CMM Plan* Employee Contribution	*PPO 80* Employee Contribution	*PPO 100* Employee Contribution	*KHP Central* Employee Contribution
Employee Only	$479	$117	$156	$200	$76
EE & Spouse/Partner	$992	$295	$388	$482	$205
EE & Child(ren)	$902	$265	$349	$434	$183
EE & Family	$1,429	$441	$571	$708	$302

Coverages the Four Medical Plans Have in Common

All Lehigh University medical coverage plans — the **CMM Plan**, **PPO 80**, **PPO 100**, and **Keystone Health Plan Central** — have identical prescription drug benefits from **Express Scripts** and vision benefits from **Davis Vision**.

Prescription Drug Benefit

A prescription plan administered by **Express Scripts** is available in each of the medical plans. It covers medications that require a prescription by either state or federal law and that are prescribed by a licensed practitioner. Insulin, insulin syringes, and needles are covered by prescription only.

You pay a percentage of the **average wholesale price** (AWP) for each prescription you fill, and the plan does not limit the number of prescriptions you may receive beyond restrictions of medical necessity, applicable legislation, or plan guidelines.

Up to a ninety-day supply of any covered medication can be dispensed at a pharmacy. In addition, you can receive up to a ninety-day supply of covered medications through the mail order prescription program. Mail order is a time- and money-saving way to get drugs you may be taking for an extended period of time.

- For all covered drugs you purchase at a pharmacy you'll pay:
  - **Generic:** Ten (10) percent of the AWP up to a maximum of $25 for each thirty-day generic prescription; $75 for 90 days;
  - **Brand Name:** Twenty (20) percent of the AWP up to a maximum of $50 for each thirty-day brand name prescription; $150 for 90 days.
- For all covered drugs you purchase through the mail order program you'll pay:
  - **Generic:** Ten (10) percent of the AWP up to a maximum of $75 for each generic prescription;
  - **Brand Name:** Twenty (20) percent of the AWP up to a maximum of $150 for each brand name prescription.

Remember that your final per prescription cost for mail order prescriptions may be lower than at your local pharmacy because the mail program buys drugs in larger quantities. As a result, you share in those savings. In addition, preventive care items as defined by The Affordable Care Act are covered in full.

Prescription Drug Maximum Costs		
In Pharmacy	**Generic**	**Brand**
30-day Supply	$25	$50
90-day Supply	$75	$150

The Preferred Drug Step Therapy Program

Lehigh's prescription drug program is based on a two-tiered formulary that determines the amount of coverage you will receive for your drugs. Those tiers are ***Generic*** and ***Name Brand*** medications. There are, however, **twelve classes of medications** in which there are preferred and non-preferred drugs:

- **PPIs** (proton pump inhibitors) —used to reduce stomach acid
- **SSRIs** (selective serotonin re-uptake inhibitors) — used to treat depression, anxiety, and some personality disorders
- **Osteoporosis —** used to strengthen fragile bones
- **ARBs** (angiotension II receptor blockers) — used to reduce blood pressure
- **INS** (intranasal steroids) — used to treat nasal allergies
- **Hypnotics** (insomnia medications) — used to treat sleep disorders
- **Triptans** — used to treat migraine
- **Glaucoma** — used to treat increased pressure in the fluid inside the eye.
- **Combination Beta2 Agonists/corticosteroids Inhalers** — used to treat asthma
- **Corticosteroids Inhalers** — used to treat asthma
- **Estrogen Replacement Therapy** — used to treat menopausal symptoms and potential calcium deficiency
- **Insulin** — used to control diabetes.

When you are prescribed a drug in one of these twelve classes, Express Scripts will use its *Preferred Drug Step Therapy Program* (PDST) to determine coverage. In general, Express Scripts considers all ingredients in the medications in each class to be equivalent. Preferred drugs are then selected based on their cost.

What To Do If You Are Prescribed A Non-Preferred Drug

If your doctor prescribes a non-preferred drug, Express Scripts will inform the pharmacist, who will then let you know that the drug isn't covered. At this point, your doctor can either change the prescription to a covered Generic or Preferred drug in the same class, or confirm to Express Scripts's satisfaction that there is evidence of a medical reason for prescribing the specific medication. The doctor will need to fill out and return a fax form with the necessary clinical information.

Express Scripts understands that some patients are either allergic to, or receive no benefit from, an equivalent Preferred medication. That is why there is an exception policy. Even if you aren't granted an exception at first, there is still another level of appeal possible. All decisions to cover the non-preferred drug, however, do require clinical evidence to justify the exception.

Non-Covered Items

The following are examples of drugs or other charges **not** covered under the **Express**

Scripts prescription plan:

- Medications lawfully obtainable without a prescription, ***excluding insulin***;
- Devices or appliances (except for diabetic supplies), such as support garments or other non-medicinal substances;
- Administration charges for drugs or insulin;
- Cosmetic drugs and medications used for cosmetic purposes (e.g., Rogaine [Minoxidil] for hair restoration and Retin-A for individuals over 19 years of age);
- Investigational or experimental drugs;
- Unauthorized refills;
- Vitamins and dietary supplements;
- Infertility drugs;
- Non-insulin injectables;
- Prescriptions covered without charge under Federal, State, or local programs, including Worker's Compensation; and
- Medications for eligible individuals confined to a rest home, nursing home, sanitarium, extended care facility, hospital, or similar entity.

This listing is neither exhaustive nor all-inclusive. If you have questions about coverage for specific medications, please address them to **Express Scripts** directly at 866-383-7420**.** You can also go to Express Scripts's website at http://www.express-scripts.com.

Vision Care Benefit

The **Davis Vision** program, offered through **Highmark Blue Shield,** is part of all medical plans offered by Lehigh. **Davis Vision** has more than 32,000 vision care providers and optical supplier locations across the United States. There are more than 3,295 providers and suppliers in Pennsylvania, with more than 195 in the Lehigh Valley area.

You and each dependent covered under your medical insurance can receive the services or supplies listed in the chart on the next page once every twelve months. If you work with a network provider/supplier, the services or materials you receive will be covered in full by the plan or covered from first dollar to the maximum level. If you go to non-participating suppliers or providers, there is a specific level of reimbursement for each service or supply the program covers.

You can receive any of the covered services and products as needed more often than once every twelve months if you use network providers or suppliers for all materials and services. When you use a network provider or supplier for additional covered services or supplies, you receive a 20 percent discount off of the provider's standard charge. If you wear both contact lenses and glasses, only one will be covered at the in-network benefit level each year. The other will be covered at the out-of-network level when you use a network provider or supplier for all materials and services. To check the network, call the number or go to the Website listed at the bottom of the chart. At the Website, follow prompts for general access or member access, as appropriate. The Lehigh University client control code for general access is **4100.**

Davis Vision Program		
Service/Product	**Your In Network Cost**	**Out-of-Network Reimbursement to You**
Eye Exam	$0	$32
Eyeglass Lenses		
Standard Single Vision	$0	$25
Bifocal	$0	$36
Trifocal	$0	$46
Post Cataract	$0	$72
Non-standard (i.e., no line bifocals, tints, coatings)	Fixed Costs	No **Additional** Benefit
Frames	$0 for Davis fashion selection frames. Amount over $60 for provider frames.	$30
Contact Lenses		
Prescription and Fitting	$0	Daily Wear: $20 Extended Wear: $30
Standard Contact Lenses	$0	$48
Specialty Contact Lenses	Amount over $75	$75
Telephone number and Web address for Davis Vision: **1-877-923-2847 (prior to initial enrollment)/1-800-999-5431 (once enrolled)** **http://www.davisvision.com**		

Creditable Coverage Disclosure Notice

The federal government requires employers to provide the notice that begins on the next page to employees who are eligible for, or who are enrolled in, full Medicare medical coverage. The notice is also required to be given to every employee dependent who meets the same conditions. One way to make sure that Lehigh carries out this responsibility is to publish the notice in materials that are made available to every employee.

Neither the notice, nor the availability of Medicare D prescription drug coverage, requires anyone who may be Medicare eligible to enroll in Medicare or to use Medicare as their insurer. Certainly, no one who is covered by a University medical plan, as an employee or a dependent, is required to enroll in Medicare or Medicare D coverage as a result of Medicare drug coverage being available. Please call **Human Resources** at **610-758-3900** if you have any questions or concerns about this required notice.

Important Notice from Lehigh University About Your Prescription Drug Coverage and Medicare October 10, 2014

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Lehigh University and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Lehigh University has determined that the prescription drug coverage offered by the Express Scripts plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Lehigh University coverage will not be affected. You can retain your existing coverage and choose not to enroll in a Part D plan now. Or, you can enroll in a Part D plan as a supplement to, or in lieu of, the other coverage.

Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current Lehigh University coverage, be aware that you and your dependents will be able to enroll back into the Lehigh University benefit

program during the open enrollment period under the plan, providing you are an active, benefits eligible employee at that time.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Lehigh University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage . . .

Contact the person listed below for further information at 610-758-3900. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Lehigh University changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage . . .

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not your are required to pay a higher premium (a penalty).

Date:	October 10, 2014
Name of Entity/Sender:	Lehigh University
Contact — Position/Office:	Director of Human Resource Services Office of Human Resources
Address:	428 Brodhead Avenue Bethlehem, PA 18015
Phone Number:	610-758-3900

LEHIGH UNIVERSITY BENEFIT PLANS
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

Lehigh University sponsors the following employee welfare benefit plans (collectively referred to as the "Plans"):

- CMM Plan, administered by Capital Blue Cross,
- PPO 80, administered by Capital Blue Cross,
- PPO 100, administered by Capital Blue Cross,
- Keystone Health Plan Central HMO, administered by Capital Blue Cross,
- Behavioral Health Benefits, administered by Magellan Behavioral Health and Integrated Behavioral Health,
- Employee Assistance Program, administered by Integrated Behavioral Health,
- United Concordia Dental, insured by United Concordia Life and Health Insurance Co.,
- Davis Vision, insured by Highmark Blue Shield,
- Express Scripts Pharmacy Benefits, administered by Express Scripts, and
- Health Care Flexible Spending Accounts, administered by WageWorks.

The Plans are required by law to maintain the privacy of your health information and to provide you with notice of their legal duties and privacy practices with respect to your health information. If you have any questions about any part of this Notice or if you want more information about the Plans' privacy practices, please contact:

Director, Human Resource Services
Lehigh University Human Resources
428 Brodhead Avenue
Bethlehem, PA 18015
Phone: 610-758-3900

How the Plans May Use or Disclose Your Health Information

The following categories describe the ways that we (the Lehigh University Benefits Staff) may use and disclose your health information. For each category of uses and disclosures, we will explain what we mean and present examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

1. Payment Functions. We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits. For example, payment functions may include confirmation of eligibility and demographic information to ensure accurate processing of enrollment changes.
2. Health Care Operations. We may use and disclose health information about you to carry out necessary insurance-related activities. For example, such activities may include submitting claims for stop-loss coverage; auditing claims payments; and planning, management, and general administration of the benefits plans.
3. Required by Law. As required by law, we may use or disclose your health information. For example, we may disclose your health information to a law enforcement official for purposes such as complying with a court order or subpoena and other law enforcement purposes; we may disclose your health information in the course of any administrative or judicial proceeding; or we may disclose your health information for military, national security, and government benefits purposes.
4. Health Oversight Activities. We may disclose your health information to health agencies in the course of audits, investigations, or other proceedings related to oversight of the health care system. For example, we will report medical plan enrollment information to the *Medicare: Coordination of Benefits IRS/SSA/CMS Data Match Project.*
5. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation or similar laws.

When the Plans May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Policies, we will not use or disclose your health information without written authorization from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though we will be unable to take back any disclosures we have already made with your permission.

Statement of Your Health Information Rights

1. Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. The Plans are not required to agree to the restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing to:

Director, Human Resource Services
Lehigh University Human Resources
428 Brodhead Avenue
Bethlehem, PA 18015.

2. Right to Request Confidential Communications. You have the right to receive your health information through a reasonable means or at an alternative location. There are two standard locations used for distribution of plan information. If you are an employee of the university, most information about the plans will be sent to your campus address. On occasion, information may be distributed through the U.S. Postal Service. The standard location for the U.S. Postal Service delivery of plan communications will be your home address, as listed in Lehigh's records. If you are not a current employee of Lehigh University, our standard location for sending plan information to you is your home address, as listed in Lehigh's records. To request an alternative means of receiving confidential communications, you must submit your request in writing to:

   Director, Human Resource Services
   Lehigh University Human Resources
   428 Brodhead Avenue
   Bethlehem, PA 18015.

   We are not required to agree to your request.

3. Right to Inspect and Copy. You have the right to inspect and copy health information about you that may be used to make decisions about your plan benefits. To inspect and copy such information, you must submit your request in writing to:

   Director, Human Resource Services
   Lehigh University Human Resources
   428 Brodhead Avenue
   Bethlehem, PA 18015.

   If you request a copy of the information, we may charge you a reasonable fee to cover expenses associated with your request.

4. Right to Request Amendment. You have the right to request that the Plans amend your health information that you believe is incorrect or incomplete. We are not required to change your health information and, if your request is denied, we will provide you with information about our denial and how you can disagree with the denial. To request an amendment, you must also provide a reason for your request in writing to:

   Director, Human Resource Services
   Lehigh University Human Resources
   428 Brodhead Avenue
   Bethlehem, PA 18015.

5. Right to Accounting of Disclosures. You have the right to receive a list or "accounting of disclosures" of your health information made by us, except that we do not have to account for disclosures made for purposes of payment functions or health care operation, or those made to you. To request this accounting, you must submit your request in writing to:

   Director, Human Resource Services
   Lehigh University Human Resources
   428 Brodhead Avenue
   Bethlehem, PA 18015.

   Your request should specify a time period of up to six years and may not include dates before April 14, 2003. The Plans will provide, on request, one list per 12-month period free of charge; we may charge you for additional lists.

6. Right to Paper Copy. You have a right to receive a paper copy of this Notice of Privacy Regulations at any time. To obtain a paper copy of this Notice, send your written request to Lehigh University Human Resources, 428 Brodhead Avenue, Bethlehem, PA 18015.You may also obtain a copy of this Notice at our website, https://hr.lehigh.edu/Open-Enrollment. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact:

   Director, Human Resource Services
   Lehigh University Human Resources
   428 Brodhead Avenue
   Bethlehem, PA 18015
   Phone: 610-758-3900

Changes to this Notice of Privacy Practices

The Plans reserve the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. We will promptly revise our Notice and distribute it to you whenever we make material changes to the Notice. Until such time, the Plans are required by law to comply with the current version of this Notice.

Complaints

Complaints about this Notice of Privacy Practices or about how we handle your health information should be directed to:

Vice President for Finance and Administration
Lehigh University
27 Memorial Drive West
Bethlehem, PA 18015
Phone: 610-758-3178

The Plans will not retaliate against you in any way for filing a complaint. All complaints about the Privacy Practices described in this Notice must be submitted in writing. If you believe your

privacy rights have been violated, you may also file a complaint with the Secretary of the Department of Health and Human Services.

Effective Date of This Notice: April 14, 2003; Updated October 16, 2012