

BENEFIT HIGHLIGHTS

CapitalBlueCross.com



PPO Plan

Lehigh University

This information is not a contract, but highlights some of the benefits available to you 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 Benefits Booklet (also known as "Certificate of Coverage"). Refer to your Benefits Booklet for complete details.

YOUR MEDICAL PLAN SUMMARY OF COST SHARING		
	Member Responsibilities	
	If provider is in-network	If provider is out-of-network
Deductible (per benefit period)	\$600 per member \$1,200 per family	\$800 per member
Coinsurance (Percentage you pay after your deductible is met.	20% coinsurance after deductible	40% coinsurance after deductible
Out-of-pocket maximum	Overall in-network out-of-pocket maximum includes deductible, copayments, and coinsurance for medical and prescription drugs: \$5,000 per member \$10,000 per family	Overall out-of-network out-of-pocket not applicable
Office Visit / Urgent Care / Emergency Room Copayments		
VirtualCare (non-specialist) visits—delivered via the Capital Blue Cross VirtualCare platform	\$10 copayment per visit	Not applicable
VirtualCare (specialist) visits—delivered via the Capital Blue Cross VirtualCare platform	\$30 copayment per visit	Not applicable
Office visits and consultations (in-person & telehealth)—performed by a family practitioner, general practitioner, internist, pediatrician network retail clinic or in-person	\$30 copayment per visit	40% coinsurance after deductible
Specialist office visits (in-person & telehealth)	\$50 copayment per visit	40% coinsurance after deductible
Urgent care services	\$50 copayment per visit	40% coinsurance after deductible
Emergency room	\$250 copayment per visit, waived if admitted	
Preventive Care		
Pediatric and adult preventive care	No charge, deductible waived	Not Covered
Screening gynecological exam and pap smear	No charge, deductible waived	40% coinsurance waive deductible
Screening mammogram	No charge, deductible waived	40% coinsurance waive deductible
Facility / Surgical Services		
Inpatient hospital room and board including maternity services and newborn care	20% coinsurance after deductible	40% coinsurance after deductible
Acute inpatient rehabilitation (60 days per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Skilled nursing facility (100 days per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Surgical procedure and anesthesia (professional charges)	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient surgery at ambulatory surgical center (facility charge only)	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient surgery at acute care hospital (facility charge only)	20% coinsurance after deductible	40% coinsurance after deductible
Diagnostic Services		
High tech imaging (such as MRI, CT, PET)	20% coinsurance after deductible	40% coinsurance after deductible
Radiology (other than high tech imaging)	20% coinsurance after deductible	40% coinsurance after deductible
Independent laboratory	20% coinsurance after deductible	40% coinsurance after deductible
Facility-owned laboratory (i.e. Health System owned)	20% coinsurance after deductible	40% coinsurance after deductible
Diagnostic mammogram	20% coinsurance after deductible	40% coinsurance after deductible
Therapy Services (Rehabilitative and Habilitative Services)		
Physical therapy (30 visits per benefit period per condition)	20% coinsurance after deductible	40% coinsurance after deductible
Occupational therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Speech therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Respiratory therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Manipulation therapy (30 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Mental Health (MH) and Substance Use Disorder Services (SUD)		
MH & SUD detoxification inpatient services	20% coinsurance after deductible	40% coinsurance after deductible
MH & SUD rehabilitation outpatient services	\$30 copayment per visit	40% coinsurance after deductible
Additional Services		
Home healthcare services (90 visits per benefit period)	20% coinsurance after deductible	40% coinsurance after deductible
Durable medical equipment and supplies; prosthetic appliances and orthotic devices	20% coinsurance after deductible	40% coinsurance after deductible

Benefits are underwritten by Capital Advantage Assurance Company®, a subsidiary of Capital Blue Cross. An independent licensee of the Blue Cross Blue Shield Association.

Deductibles, coinsurance and copayments under this program are separate from any deductibles, coinsurance and copayments required under any other health benefits coverage you may have.

In-network providers agree to accept our allowance as payment in full—often less than their normal charge. If you visit an out-of-network provider, you are responsible for paying the deductible, coinsurance and the difference between the out-of-network provider's charges and the allowed amount. Out-of-network providers may balance bill the member. Some out-of-network facility providers are not covered. In certain situations, a facility fee may be associated with an outpatient visit to a professional provider. Members should consult with the provider of the services to determine whether a facility fee may apply to that provider. An additional cost-sharing amount may apply to the facility fee.

Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.

2026 Schedule of Preventive Care Services

This information highlights the preventive care services available under this *coverage* and lists items/services required under the Patient Protection and Affordable Care Act of 2010 (PPACA), as amended. It is reviewed and updated periodically based on the recommendations of the U.S. Preventive Services Task Force (USPSTF); Health Resources and Services Administration (HRSA), Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services (HHS), and other applicable laws and regulations. Accordingly, the content of this schedule is subject to change.

Your specific needs for preventive services may vary according to your personal risk factors. It is not intended to be a complete list or complete description of available services. In-network preventive services are provided at no Member cost-share. Additional diagnostic studies may be covered if *medically necessary* for a particular diagnosis or procedure; if applicable, these diagnostic services may be subject to cost-sharing. 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*.

Schedule for Adults: Age 19 years and older

GENERAL HEALTHCARE*

For routine history and physical examination, including pertinent patient education. Adult counseling and patient education include:

Women

- Breast Cancer Chemoprevention - Contraceptive Methods/Counseling¹ - Folic Acid (childbearing age)	- Hormone Replacement Therapy (HRT) – Risk vs. Benefits - Urinary Incontinence Assessment	At least annually
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Men and Women

- Aspirin Prophylaxis (high-risk) - Drug Use - Family Planning - Fall Prevention (age 65 and older)	- Physical Activity/Exercise - Seat Belt Use - Statin Medication (high-risk) - Unintentional Injuries	At least annually
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SCREENINGS/PROCEDURES*

Women (Preventive care for pregnant women, see Maternity section.)

Bone Mineral Density (BMD) Test	Age 65 and older, test every 2 years. Age 19-64, test if postmenopausal and at risk for osteoporosis.
BRCA Screening/Genetic Counseling/Testing	BRCA screening and counseling if at risk and not previously diagnosed with BRCA-related cancer and who have a personal or family history of cancer. BRCA testing once per lifetime if recommended by your healthcare provider.
Domestic/Intimate/Partner Violence Screening and Support	Age 19 and older: Screening annually and offer support services as determined by your healthcare provider.
Mammogram (2D or 3D)	Beginning at age 40, every 1-2 years for women at average risk for breast cancer. Includes one additional MRI or ultrasound and patient navigation services, as determined by your healthcare provider.
Obesity in Midlife Women	Age 40-60 with normal to overweight body mass index (BMI), offer counseling to prevent obesity.
Pelvic Exam/Pap Smear/HPV DNA	Pelvic Exam/Pap Smear: Age 21-65: every 3 years; HPV DNA: Age 30-65, every 5 years. Offer patient navigation services, as determined by your healthcare provider.

Men

Abdominal Aortic Aneurysm Screening	Age 65-75, one-time screening for abdominal aortic aneurysm in men who have ever smoked.
Prostate Cancer Screening	Beginning at age 50, annually. Begin at age 19 for high-risk males.
Prostate Specific Antigen	Beginning at age 50, annually.

Men and Women

Alcohol Use Screening/Counseling	Age 19 and older: Offer behavioral counseling interventions for adults who are engaged in risky or hazardous drinking.
Anxiety/Depression Screening	Age 19 and older: Annually or as determined by your healthcare provider.
Cardiovascular Disease Prevention	Age 19 and older at increased risk of cardiovascular disease (CVD); screening and offer behavioral counseling.
Chlamydia and Gonorrhea Test	Age 19-24 years, test all sexually active women and 25 years and older test based on individual risk and recommendation by your healthcare provider. Test as recommended when prescribed HIV PrEP.
CT Colonography ²	Beginning at age 45, every 5 years.
Colonoscopy ³	Beginning at age 45, every 10 years.
Diabetes Screening	Age 35-70, screening tests in primary care settings if overweight or obese (with a BMI of 25 or greater). If normal, rescreen every 3 years. Offer prevention interventions, as determined by your healthcare provider.
Fasting Lipid Profile	Beginning at age 20, every 5 years.
Fecal Occult Blood Test (gFOBT/FIT) ⁴	Beginning at age 45, annually.
FIT-DNA Test	Beginning at age 45, every 1-3 years.
Flexible Sigmoidoscopy ³	Beginning at age 45, every 5 years.
Hepatitis B Test	Age 19 and older if at high risk. Periodic repeat testing with continued risk factors.
Hepatitis C Test	Age 19 and older, offer one-time testing. Periodic repeat testing with continued risk factors.
High Blood Pressure (HBP)	Age 19-39, testing every 3-5 years with no other risk factors. Age 40 and older, or younger if at increased risk, test annually.

HIV PrEP Medication with related Testing/Counseling	If prescribed HIV Preexposure Prophylaxis (PrEP) medications, offer related testing and counseling services as determined by your healthcare provider.
HIV Test	Age 19-65, offer one time testing with unknown risk for HIV. Periodic repeat testing with continued risk factors.
Latent Tuberculosis (TB) Infection Test	Age 19 and older at high risk, offer one time testing. Periodic repeat testing with continued risk factors.
Low-dose CT Scan for Lung Cancer	Age 50-80 at high risk, test annually until smoke-free for 15 years.
Obesity/Weight Loss Interventions	Age 19 and older with a BMI of 30 or greater: Offer behavioral interventions.
STI Counseling	Age 19 and older at increased risk: Behavioral counseling as determined by your healthcare provider.
Skin Cancer Prevention Counseling	Age 19-24: Counseling to minimize exposure to ultraviolet (UV) radiation for adults with fair skin.
Syphilis Test	Age 19 and older test if at high-risk. Periodic repeat testing with continued risk factors as determined by your healthcare provider.
Tobacco Use Assessment/Counseling/Cessation Interventions	Age 19 and older: 2 cessation attempts per year including behavioral counseling interventions (each attempt includes a maximum of 4 counseling visits of at least 10 minutes per session); Food and Drug Administration (FDA)-approved tobacco cessation medications. ⁵
IMMUNIZATIONS**	
COVID-19	Age 19 and older: 2 or 3 dose primary series and booster.
Haemophilus Influenza Type B (Hib)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 1 or 3 doses depending on indication.
Hepatitis A (HepA)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 2, 3 or 4 doses.
Hepatitis B (HepB)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 2 to 4 doses.
Human Papillomavirus (9vHPV)	Age 19-45: 2 or 3 doses, depending on age at series initiation or healthcare provider recommendation.
Influenza	Age 19 and older: 1 dose annually.
Measles/Mumps/Rubella (MMR)	Age 19 and older: Based on indication (born 1957 or later) or healthcare provider recommendation, 1 or 2 doses.
Meningococcal A, C, W, Y	Age 19 and older: Based on individual risk or healthcare provider recommendation, 1 or 2 doses depending on indication, then booster every 5 years if risk remains.
Meningococcal B (MenB)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 2 or 3 doses depending on indication, then booster every 2-3 years if risk remains.
Monkeypox (Mpox)	Age 19 and older based on individual risk or healthcare provider recommendation, 2 doses.
Pneumococcal (PCV)	Age 19 and older: Based on individual risk and healthcare provider recommendation, 1 or 2 doses.
Respiratory Syncytial Virus (RSV)	Age 50 and older: Based on individual risk and healthcare provider recommendation, 1 dose annually.
Tetanus/Diphtheria/Pertussis (Td/Tdap)	Age 19 and older: 1 dose of Tdap, then Td or Tdap booster every 10 years.
Varicella/Chickenpox (VAR)	Beginning at age 19: 1 or 2 doses (born 1980 or later) based upon past immunization or medical history.
Zoster/Shingles (RZV)	Age 19 and older: Based on individual risk or healthcare provider recommendation, 2 doses.

¹ Coverage is provided without cost-share for all FDA-approved contraceptive methods. See the Rx Preventive Coverage List at [capitalbluecross.com](https://www.capitalbluecross.com) for details. Coverage includes clinical services, including patient education and counseling, needed for provision of the contraceptive method. If a member's provider recommends a specific FDA-approved method based on medical necessity, the service or item is covered without cost-sharing.

² CT Colonography is listed as an alternative to a flexible sigmoidoscopy and colonoscopy.

³ Only one endoscopic procedure is covered at a time.

⁴ For guaiac-based testing (gFOBT), six stool samples are obtained (2 samples on each of 3 consecutive stools, while on appropriate diet, collected at home). For immunoassay testing (FIT), specific manufacturer's instructions are followed.

⁵ Refer to the most recent formulary located on the Capital Blue Cross website at [capitalbluecross.com](https://www.capitalbluecross.com).

Schedule for Maternity

SCREENING/PROCEDURES*

The recommended services listed below are considered preventive care (including prenatal visits) for pregnant women. You may receive the following screenings and procedures at no member cost share:

- Alcohol Use Screening/Counseling
- Anemia Screening (CBC)
- Anxiety/Depression Screening (prenatal/postpartum)
- Breastfeeding Support/Counseling/Supplies
- Gestational Diabetes Screening (prenatal/postpartum)
- Healthy Weight Gain during Pregnancy
- Hepatitis B Screening (first prenatal visit)
- HIV Screening•
- Low-dose Aspirin Therapy (after 12 weeks gestation with high-risk for preeclampsia)
- Preeclampsia Screening
- Rh Blood Typing
- Rh Antibody Testing for Rh-negative Women
- Rubella Titer
- STI Screening/Testing (Chlamydia/Gonorrhea/Syphilis)
- Tobacco Use Assessment, Counseling and Cessation Interventions
- Urine Bacteria Screening (Asymptomatic)
- Other preventive services may be available as determined by your healthcare provider

* Services that need to be performed more frequently than stated due to specific health needs of the member and 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. If a clinician determines that a patient requires more than one well-woman visit annually to obtain all necessary recommended preventive services, the additional visits will be provided without cost-sharing. Occupational, school, and other "administrative" exams are not covered.

** Refer to the guidelines set forth by the Centers for Disease Control and Prevention (CDC) for additional immunization information.

	Newborn	9-12 months	1 year	2 years	3 years	4 years	5 years	6 years	7 years	8 years	9 years	10 years	11 years	12 years	13 years	14 years	15 years	16 years	17 years	18 years	19 years
SCREENINGS/PROCEDURES*																					
STI Screening/Counseling	Beginning at 11 years (at risk, if sexually active): Offer behavioral counseling.											✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Skin Cancer Prevention Counseling	Beginning at 6 months, counseling to minimize exposure to ultraviolet (UV) radiation for children with fair skin.																				
Syphilis Test	For high-risk children; suggested testing interval is 1-3 years.																				
Tobacco Smoking Screening and Cessation	Beginning at age 18: Two (2) cessation attempts per year including behavioral counseling interventions; (each attempt includes a maximum of 4 counseling visits); FDA approved tobacco cessation medications ³																			✓	✓
Tuberculin Test	Assess risk at every well child visit, test if recommended by healthcare provider.																				
Vision Risk Assessment	Up to 2½ years						✓		✓		✓		✓	✓		✓	✓	✓	✓	✓	
Vision Test (objective method)					✓	✓	✓	✓		✓		✓		✓			✓				
	Optional annual instrument-based testing may be used between 1-5 years of age and between 6-19 years of age in uncooperative children.																				
IMMUNIZATIONS**																					
COVID-19	6 months – 18 years; 2 or 3 primary dose series and booster																				
Diphtheria/Tetanus/Pertussis (DTaP)	2 months, 4 months, 6 months, 15–18 months, 4–6 years; 5 doses																				
Haemophilus Influenza Type B (Hib)	2 months, 4 months, 6 months, 12–15 months, and 1–18 years based on individual risk; 3 or 4 doses																				
Hepatitis A (HepA)	12–23 months; 2 doses																				
Hepatitis B (HepB)	Birth, 1–2 months, 6–18 months; 3 doses																				
Human Papillomavirus (HPV)	9-18 years: Starting age and doses are based on individual risk and healthcare provider recommendations; 2 or 3 doses																				
Influenza ⁴	6 months–18 years; annual vaccination, 1 or 2 doses																				
Measles/Mumps/Rubella (MMR)	12–15 months, 4–6 years; 2 doses																				
Meningococcal	11–12 years, 16 years; 2 months–18 years for those at high-risk; 2 doses																				
Meningococcal B (MenB)	10–18 years based on individual risk or healthcare provider recommendation; 2 or 3 doses																				
Monkeypox (Mpox)	Age 18 and older based on individual risk or healthcare provider recommendation, 2 doses																				
Pneumococcal (PCV)	2 months, 4 months, 6 months, 12–15 months and 2-18 years based on individual risk and healthcare provider recommendation; 4 doses																				
Polio (IPV)	2 months, 4 months, 6–18 months, 4–6 years; 4 doses																				
Respiratory Syncytial Virus (RSV)	Birth, 1–19 months; 1 dose. Children up to 24 months based on individual risk or healthcare provider recommendation; 1 dose annually																				
Rotavirus (RV)	2 months, 4 months, 6 months; 2 or 3 doses																				
Tetanus/Reduced Diphtheria/Pertussis (Tdap)	11–12 years; 1 dose																				
Varicella/Chickenpox (VAR)	12–15 months, 4–6 years; 2 doses																				

¹ Fluoride supplementation pertains only to children who reside in communities with inadequate water fluoride.

² Encourage all PA Children's Health Insurance Program (CHIP) Members to undergo blood lead level testing before age 2 years. If not previously tested, test between the ages of 3 to 6 years old.

³ Refer to the most recent formulary located on the Capital Blue Cross web site at [capitalbluecross.com](https://www.capitalbluecross.com).

⁴ Children aged 6 months to 8 years who are receiving influenza vaccines for the first time should receive 2 separate doses (greater than 4 weeks apart), both of which are covered.

* Services that need to be performed more frequently than stated due to specific health needs of the member and 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. If a clinician determines that a patient requires more than one well-woman visit annually to obtain all necessary recommended preventive services, the additional visits will be provided without cost-sharing. Occupational, school, and other "administrative" exams are not covered.

** Refer to the guidelines set forth by the Centers for Disease Control and Prevention (CDC) for additional immunization information including special situations and catch-up vaccinations if necessary.

This preventive schedule is periodically updated to reflect current recommendations from the U.S. Preventive Services Task Force (USPSTF); Health Resources and Services Administration (HRSA); 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); U.S. Food and Drug Administration (FDA); American Academy of Pediatrics (AAP); Women's Preventive Services Initiative (WPSI).

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.



This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage: about health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; about prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; and about vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$600/individual/\$1200/family participating providers ; \$800/individual non-participating providers .	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Network preventive services .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For participating providers \$5,000 individual / \$10,000 family; for non-participating providers \$0 individual combined out-of-pocket limit for medical and prescription drug .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Pre-authorization penalties, premiums , balance billing charges, vision care costs, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. For a list of participating providers , see www.capbluecross.com or call 1-800-962-2242. See www.davisvision.com or call 1-800-999-5431 for vision care participating providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copayment /visit	40% coinsurance	None
	Specialist visit	\$50 copayment /visit	40% coinsurance	None
	Preventive care/screening /immunization	No charge	Mandated screening and immunizations 40% coinsurance ; Routine Physical exams; Not covered	Deductible does not apply to services at participating providers . You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance for lab and 20% coinsurance for tests. 20% coinsurance for outpatient radiology.	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
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	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.
	Preferred brand drugs	25% coinsurance (retail and mail order)	25% 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	35% coinsurance (retail and mail order)	35% 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	25% coinsurance for preferred brand drugs and 35% coinsurance For non-preferred brand drugs	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	40% coinsurance	Services at non-participating ambulatory surgical facilities 40% coinsurance .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need immediate medical attention	Emergency room care	\$250 copayment /visit	\$250 copayment /visit	Deductible does not apply. Copayment waived if admitted inpatient.
	Emergency medical transportation	20% coinsurance	40% coinsurance	Deductible does not apply.
	Urgent care	\$50 copayment /visit	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copayment /visit	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	\$50 copayment /visit	40% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	90 visit limit *See preauthorization schedule attached to your certificate of coverage.
	Rehabilitation services	20% coinsurance	40% coinsurance	30 visit limit
	Habilitation services	20% coinsurance	40% coinsurance	30 visit limit
	Skilled nursing care	20% coinsurance	40% coinsurance	100 day limit
	Durable medical equipment	20% coinsurance	40% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Hospice services	20% coinsurance	40% 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.	Children's eye exam	No charge	Full cost less \$32	Limited to one exam per year
	Children's glasses	No charge for standard lenses and select frames; Amount over \$100 for provider frames	Full cost less \$55 for standard lenses and any frame	Limited to one pair of glasses per year
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- | | | |
|--|------------------|--|
| • Acupuncture | • Dental care | • Routine foot care (unless medically necessary) |
| • Bariatric Surgery (unless medically necessary) | • Hearing aids | • Weight loss programs |
| • Cosmetic Surgery | • Long-term care | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|-------------------------|--|------------------------|
| • Chiropractic Care | • Non-emergency care when traveling outside the U.S. | • Private-duty nursing |
| • Infertility treatment | | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: for health care coverage, contact Capital Blue Cross at 1-800-216-9741 or www.capbluecross.com; for prescription drug coverage, contact Express Scripts at 1-866-383-7420 or www.express-scripts.com; and for vision coverage, contact Davis Vision at 1-800-999-5431 or www.davisvision.com. or the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Language assistance

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).

欲免费用本国语言洽询传译员，请拨电话 800.962.2242 (TTY: 711).

Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi

800.962.2242 (TTY: 711).

Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).

Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).

무료 전화 통역 서비스 800.962.2242 (TTY: 711).

Per parlare con un interprete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711)

711: (الهاتف النصي) 800.962.2242 يرجى الاتصال بـ (المتحدث مجاًناً إلى مترجم للغتك،

Pour parler à un interprète dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).

Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

දුරකථන මගින් නොමිලට සහන දීම, 800.962.2242 (TTY: 711) ට කඳවුරු දෙන්න.

Aby porozmawiac z tłumaczem w języku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY: 711)

Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 800.962.2242 (TTY: 711).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមទូរស័ព្ទលេខ 800.962.2242 (TTY: 711)

Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).

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OMB control number: 0938-1146/Expiration date: 05/31/2026

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$600
■ Specialist [<i>cost sharing</i>]	\$50
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$2,400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$600
■ Specialist [<i>cost sharing</i>]	\$50
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$300
Coinsurance	\$900
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$600
■ Specialist [<i>cost sharing</i>]	\$50
■ Hospital (facility) [<i>cost sharing</i>]	20%
■ Other [<i>cost sharing</i>]	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$400
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1300