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. **$6,350/**person **$12,700/**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**.

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; about mental/behavioral health or substance abuse: 1-800-395-1616 or www.ibhcorp.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 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:

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.

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; about mental/behavioral health or substance abuse: 1-800-395-1616 or www.ibhcorp.com; and about vision care coverage: **1-800-999-5431** or www.davisvision.com.

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