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| |  | | --- | | **Summary of Benefits and Coverage**: What this Plan Covers & What You Pay For Covered Services | | |  | | --- | | **Coverage Period: Beginning on or after 06/01/2023** | |
| |  |  |  | | --- | --- | --- | |  | |  | | --- | | **Personal Choice PPO Villanova University** | | | |  | | --- | | **Coverage for**: Family | **Plan Type**: PPO | |

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| |  |  |  | | --- | --- | --- | |  | |  | | --- | | **The Summary of Benefits and Coverage (SBC) document will help you choose a health** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**. The SBC shows you how you and the** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **would share the cost for covered health care services. NOTE: Information about the cost of this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **(called the** [**premium**](https://www.healthcare.gov/sbc-glossary/#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, visit [www.ibx.com/LGBooklet](https://www.ibx.com/LGBooklet) or by calling 1-800-ASK-BLUE (TTY:711). For general definitions of common terms, such as [allowed amount](https://www.healthcare.gov/sbc-glossary/#allowed-amount), [balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing), [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance), [copayment](https://www.healthcare.gov/sbc-glossary/#copayment), [deductible](https://www.healthcare.gov/sbc-glossary/#deductible), [provider](https://www.healthcare.gov/sbc-glossary/#provider), or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](https://www.healthcare.gov/sbc-glossary/) or call 1-800-ASK-BLUE (TTY:711) to request a copy. | | | |

| **Important Questions** | **Answers** | **Why This Matters:** |
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| |  | | --- | | **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | | |  | | --- | | For [In-Network providers](https://www.healthcare.gov/sbc-glossary/#network-provider) $300 person / $900 family; For [Out-of-Network providers](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) $1,500 person / $4,500 family. | | |  | | --- | | Generally, you must pay all of the costs from [providers](https://www.healthcare.gov/sbc-glossary/#provider) up to the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount before this [plan](https://www.healthcare.gov/sbc-glossary/#plan) begins to pay. If you have other family members on the [plan](https://www.healthcare.gov/sbc-glossary/#plan), each family member must meet their own individual [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) until the total amount of [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) expenses paid by all family members meets the overall family [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). | |
| |  | | --- | | **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** | | |  | | --- | | Yes. [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care), Primary care services, [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) services and [Emergency room services](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) are covered before you meet your [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). | | |  | | --- | | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers some items and services even if you haven't yet met the [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) amount. But a [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) or [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. For example, this [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers certain [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) without [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) and before you meet your [deductible](https://www.healthcare.gov/sbc-glossary/#deductible). See a list of covered [preventive services](https://www.healthcare.gov/sbc-glossary/#preventive-care) at <https://www.healthcare.gov/coverage/preventive-care-benefits/>. | |
| |  | | --- | | **Are there other** [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** | | |  | | --- | | No. | | |  | | --- | | You don't have to meet [deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) for specific services. | |
| |  | | --- | | **What is the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) **for this** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan)**?** | | |  | | --- | | For [In-Network providers](https://www.healthcare.gov/sbc-glossary/#network-provider) $3,000 person / $9,000 family; For [Out-of-Network providers](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) $6,000 person / $18,000 family. | | |  | | --- | | The [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#plan), they have to meet their own [out-of-pocket limits](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) until the overall family [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit) has been met. | |
| |  | | --- | | **What is not included in the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** | | |  | | --- | | [Premiums](https://www.healthcare.gov/sbc-glossary/#premium), balance-billing charges, and health care this [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn't cover. | | |  | | --- | | Even though you pay these expenses, they don't count toward the [out-of-pocket limit](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit). | |
| |  | | --- | | **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** | | |  | | --- | | Yes. See [www.ibx.com/find\_a\_provider](https://www.ibx.com/find_a_provider) or call 1-800-ASK-BLUE (TTY:711) for a list of [network providers](https://www.healthcare.gov/sbc-glossary/#network-provider). | | |  | | --- | | This [plan](https://www.healthcare.gov/sbc-glossary/#plan) uses a [provider](https://www.healthcare.gov/sbc-glossary/#provider) [network](https://www.healthcare.gov/sbc-glossary/#network). You will pay less if you use a [provider](https://www.healthcare.gov/sbc-glossary/#provider) in the [plan's](https://www.healthcare.gov/sbc-glossary/#plan) [network](https://www.healthcare.gov/sbc-glossary/#network). You will pay the most if you use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider), and you might receive a bill from a [provider](https://www.healthcare.gov/sbc-glossary/#provider) for the difference between the [provider's](https://www.healthcare.gov/sbc-glossary/#provider) charge and what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) pays ([balance billing](https://www.healthcare.gov/sbc-glossary/#balance-billing)). Be aware your [network provider](https://www.healthcare.gov/sbc-glossary/#network-provider) might use an [out-of-network provider](https://www.healthcare.gov/sbc-glossary/#out-of-network-provider) for some services (such as lab work). Check with your [provider](https://www.healthcare.gov/sbc-glossary/#provider) before you get services. | |
| |  | | --- | | **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** | | |  | | --- | | No. | | |  | | --- | | You can see the [specialist](https://www.healthcare.gov/sbc-glossary/#specialist) you choose without a [referral](https://www.healthcare.gov/sbc-glossary/#referral). | |

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| |  |  |  | | --- | --- | --- | |  | |  | | --- | | All [copayment](https://www.healthcare.gov/sbc-glossary/#copayment) and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) costs shown in this chart are after your [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) has been met, if a [deductible](https://www.healthcare.gov/sbc-glossary/#deductible) applies. | | |

|  |  | **What You Will Pay** | |  |
| --- | --- | --- | --- | --- |
| **Common Medical Event** | **Services You May Need** | |  | | --- | | **In-Network Provider**  **(You will pay the least)** | | |  | | --- | | **Out-of-Network Provider (You will pay the most)** | | **Limitations, Exceptions, & Other Important Information** |
| |  | | --- | | **If you visit a health care** [**provider's**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** |  |  | | --- | |  | | Primary care visit to treat an injury or illness | |  |  | | --- | --- | | |  | | --- | | $30/Visit. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  | | --- | | Telemedicine (from designated telemedicine [provider](https://www.healthcare.gov/sbc-glossary/#provider), [www.ibx.com/findcarenow](https://www.ibx.com/findcarenow)): $10/Visit. Additional [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) may apply when you receive other services at your [provider's](https://www.healthcare.gov/sbc-glossary/#provider) office. | |
| |  | | --- | | [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit | | |  |  | | --- | --- | | |  | | --- | | $50/Visit. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  | | --- | | Additional [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) may apply when you receive other services at your [provider's](https://www.healthcare.gov/sbc-glossary/#provider) office. | |
| |  | | --- | | [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#screening)/immunization | | |  |  | | --- | --- | | |  | | --- | | No charge. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | | |  | | --- | | Age and frequency schedules may apply. You may have to pay for services that aren't preventive. Ask your [provider](https://www.healthcare.gov/sbc-glossary/#provider) if the services needed are preventive. Then check what your [plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay for. | |
| |  | | --- | | **If you have a test** |  |  | | --- | |  | | |  | | --- | | [Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) | | |  | | --- | | X-Ray: $30/Visit. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply.  Blood Work: No charge. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | |  | | --- | | None | |
| |  | | --- | | Imaging (CT/PET scans, MRIs) | | |  | | --- | | $50/Scan. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | |  | | --- | | Precertification required for certain services. \*See section General Information. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. | |
| **If you need drugs to treat your illness or condition**   |  | | --- | |  |  |  | | --- | |  | | |  | | --- | | Generic Drugs | | |  | | --- | | $10 copay / $25 copay | | |  | | --- | | Submit a direct claim form. | | |  | | --- | | None | |
| |  | | --- | | Preferred Brand | | |  | | --- | | $30 copay / $75 copay | | |  | | --- | | Submit a direct claim form. | | |  | | --- | | None | |
| |  | | --- | | Non Preferred Drugs | | |  | | --- | | $50 copay / $125 copay | | |  | | --- | | Submit a direct claim form. | | |  | | --- | | None | |
| SaveOnSP Specialty Drugs | 30% Coinsurance | Not Covered | Coinsurance for select specialty medications will equal 30%, unless you enrolled in SaveOnSP. The 30% coinsurance does not apply to deductible or out-of-pocket maximum. If you enroll in the SaveOnSP program, there is a $0 copay for Specialty Drugs on SaveOnSP Specialty Drug List. |
| |  | | --- | | [Specialty Drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) | | |  |  | | --- | --- | | |  | | --- | | $50 copay / prescription fill | | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  | | --- | | This cost share amount is for specialty injectable or infusion therapy drugs covered by the medical benefit. These drugs are typically administered by a health care professional in a home/office or outpatient facility. Prior-authorization required. \*See section Outpatient Services. | |
| |  | | --- | | **If you have outpatient surgery** |  |  | | --- | |  | | |  | | --- | | Facility fee (e.g., ambulatory surgery center) | | |  | | --- | | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | |  | | --- | | Precertification may be required. \*See section General Information. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. | |
| |  | | --- | | Physician/surgeon fees | | |  |  | | --- | --- | | |  | | --- | | No charge. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | |
| |  | | --- | | **If you need immediate medical attention** |  |  | | --- | |  | | |  | | --- | | [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) | | |  |  | | --- | --- | | |  | | --- | | $100/Visit. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | | |  | | --- | | Covered at In-Network level. | | |  | | --- | | None | |
| |  | | --- | | [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) | | |  |  | | --- | --- | | |  | | --- | | No charge. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | | |  | | --- | | Covered at In-Network level. | |
| |  | | --- | | [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) | | |  |  | | --- | --- | | |  | | --- | | $50/Visit. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | |  | | --- | | Your costs for [urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) are based on care received at a designated [urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) center or facility, not your physician's office. Costs may vary depending on where you receive care. | |
| |  | | --- | | **If you have a hospital stay** |  |  | | --- | |  | | |  | | --- | | Facility fee (e.g., hospital room) | | |  |  | | --- | --- | | |  | | --- | | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  | | --- | | Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. | |
| |  | | --- | | Physician/surgeon fees | | |  |  | | --- | --- | | |  | | --- | | No charge. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | |
| |  | | --- | | **If you need mental health, behavioral health, or substance abuse services** |  |  | | --- | |  | | |  | | --- | | Outpatient services | | |  |  | | --- | --- | | |  | | --- | | $30/Visit. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  | | --- | | Precertification may be required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. | |
| |  | | --- | | Inpatient services | | |  |  | | --- | --- | | |  | | --- | | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  | | --- | | Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. | |
| |  | | --- | | **If you are pregnant** |  |  | | --- | |  | | |  | | --- | | Office visits | | |  |  | | --- | --- | | |  | | --- | | $30/Visit. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  | | --- | | Office visit cost share applies to the first OB visit only. Depending on the type of services, additional [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) or [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested for maternity care. | |
| |  | | --- | | Childbirth/delivery professional services | | |  |  | | --- | --- | | |  | | --- | | No charge. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | |
| |  | | --- | | Childbirth/delivery facility services | | |  |  | | --- | --- | | |  | | --- | | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  | | --- | | Office visit cost share applies to the first OB visit only. Depending on the type of services, additional [copayments](https://www.healthcare.gov/sbc-glossary/#copayment) or [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested for maternity care. | |
| |  | | --- | | **If you need help recovering or have other special health needs** |  |  | | --- | |  | | |  | | --- | | [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) | | |  |  | | --- | --- | | |  | | --- | | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  | | --- | | Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. | |
| |  | | --- | | [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) | | |  | | --- | | $50/Visit. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | |  | | --- | | 20% reduction in benefits for failure to precert out-of-network or BlueCard services. Physical/Occupational Therapies: 30 visits combined/Contract Year. Speech Therapy: 20 visits/Contract Year. All visit limits combined in and out-of-network. | |
| |  | | --- | | [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) | | |  | | --- | | $50/Visit. [Deductible](https://www.healthcare.gov/sbc-glossary/#deductible) does not apply. | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | |  | | --- | | 20% reduction in benefits for failure to precert out-of-network or BlueCard services. Physical/Occupational Therapies: 30 visits combined/Contract Year. Speech Therapy: 20 visits/Contract Year. All visit limits combined in and out-of-network. | |
| |  | | --- | | [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) | | |  |  | | --- | --- | | |  | | --- | | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  | | --- | | Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. 120 visits/Contract Year. Visit limits combined in and out-of-network. | |
| |  | | --- | | [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  |  | | --- | --- | | |  | | --- | | 50% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  | | --- | | Precertification required for selected items. \*See section General Information. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. | |
| |  | | --- | | [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) | | |  |  | | --- | --- | | |  | | --- | | 10% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  |  | | --- | --- | | |  | | --- | | 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). | | | |  | | --- | | Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. | |
| |  | | --- | | **If your child needs dental or eye care** |  |  | | --- | |  |  |  | | --- | |  | | |  | | --- | | Children's eye exam | | |  | | --- | | $0/Visit | | |  | | --- | | $35 reimbursement | | |  | | --- | | Once every contract year | |
| |  | | --- | | Children's glasses | | |  | | --- | | Covered 100% on all Davis collection | | |  | | --- | | $100 reimbursement | | |  | | --- | | Once every contract year | |
| |  | | --- | | Children's dental check-up | | |  | | --- | | Not covered. | | |  | | --- | | Not covered. | | |  | | --- | | None | |
| |  | | --- | |  | |  |  |  |  |

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| **Excluded Services & Other Covered Services:** |

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| |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | **Services Your** [**Plan**](https://www.healthcare.gov/sbc-glossary/#plan) **Generally Does NOT Cover (Check your policy or** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document for more information and a list of any other** [**excluded services**](https://www.healthcare.gov/sbc-glossary/#excluded-services)**.)** | | | | | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | • | | |  | | --- | | Cosmetic surgery | | | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | • | | |  | | --- | | Dental care (Adult) | | | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | • | | |  | | --- | | Hearing aids | | | | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | • | | |  | | --- | | Long-term care | | | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | • | | |  | | --- | | Routine eye care (Adult) | | | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | • | | |  | | --- | | Routine foot care | | | | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | • | | |  | | --- | | Weight loss programs | | |  |  | |

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| |  | | --- | | **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your** [**plan**](https://www.healthcare.gov/sbc-glossary/#plan) **document.)** | | | |
| |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | • | | |  | | --- | | Acupuncture | | | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | • | | |  | | --- | | Bariatric surgery | | | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | • | | |  | | --- | | Chiropractic care | | |
| |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | • | | |  | | --- | | Infertility treatment (covered for artificial insemination and assisted reproductive technology) | | | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | • | | |  | | --- | | Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com | | | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | • | | |  | | --- | | Private-duty nursing | | |
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| **Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. To contact the [plan](https://www.healthcare.gov/sbc-glossary/#plan) at 1-800-ASK-BLUE (TTY: 711)or the contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](https://www.dol.gov/ebsa/healthreform); For non-federal governmental group health [plans](https://www.healthcare.gov/sbc-glossary/#plan), contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or [www.cciio.cms.gov](https://www.cciio.cms.gov). Church [plans](https://www.healthcare.gov/sbc-glossary/#plan) are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, you should contact your State Insurance regulator regarding possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace). For more information about the [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace), visit [www.HealthCare.gov](https://www.HealthCare.gov) or call 1-800-318-2596. |

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| **Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](https://www.healthcare.gov/sbc-glossary/#plan) for a denial of a [claim](https://www.healthcare.gov/sbc-glossary/#claim). This complaint is called a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) or [appeal](https://www.healthcare.gov/sbc-glossary/#appeal). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](https://www.healthcare.gov/sbc-glossary/#claim). Your [plan](https://www.healthcare.gov/sbc-glossary/#plan) documents also provide complete information to submit a [claim](https://www.healthcare.gov/sbc-glossary/#claim), [appeal](https://www.healthcare.gov/sbc-glossary/#appeal), or a [grievance](https://www.healthcare.gov/sbc-glossary/#grievance) for any reason to your [plan](https://www.healthcare.gov/sbc-glossary/#plan). For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA, contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](https://www.dol.gov/ebsa/healthreform); for non-federal governmental group health [plans](https://www.healthcare.gov/sbc-glossary/#plan) and church [plans](https://www.healthcare.gov/sbc-glossary/#plan) that are group health [plans](https://www.healthcare.gov/sbc-glossary/#plan), contact us at 1-800-ASK-BLUE (TTY:711); if the coverage is insured, you may also contact the Pennsylvania Insurance Department - 1-877-881-6388 - [http://www.insurance.pa.gov/Consumers](https://www.insurance.pa.gov/Consumers). |

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| **Does this plan provide Minimum Essential Coverage? Yes.**  If you don’t have [Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month. |

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| **Does this plan meet Minimum Value Standards?** **Yes.**  If your [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn’t meet the [Minimum Value Standards](https://www.healthcare.gov/sbc-glossary/#minimum-value-standard), you may be eligible for a [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits) to help you pay for a [plan](https://www.healthcare.gov/sbc-glossary/#plan) through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace). |

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

**About these Coverage Examples:**

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| |  |  |  | | --- | --- | --- | |  | |  | | --- | | **This is not a cost estimator.** Treatments shown are just examples of how this [plan](https://www.healthcare.gov/sbc-glossary/#plan) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](https://www.healthcare.gov/sbc-glossary/#provider) charge, and many other factors. Focus on the [cost sharing](https://www.healthcare.gov/sbc-glossary/#cost-sharing) amounts  ([deductibles](https://www.healthcare.gov/sbc-glossary/#deductible), [copayments](https://www.healthcare.gov/sbc-glossary/#copayment), and [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance)) and [excluded services](https://www.healthcare.gov/sbc-glossary/#excluded-services) under the [plan](https://www.healthcare.gov/sbc-glossary/#plan). Use this information to compare the portion of costs you might pay under different health [plans](https://www.healthcare.gov/sbc-glossary/#plan). Please note these coverage examples are based on self-only coverage. | | |
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| |  | | --- | | **Peg is Having a Baby**  (9 months of in-network pre-natal care and a  hospital delivery) | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | |  | | --- | | **The** [**plan's**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) | | |  | | --- | | **$300** | | | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | |  | | --- | | [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | | |  | | --- | | **$50** | | | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | |  | | --- | | **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) | | |  | | --- | | **10%** | | | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | |  | | --- | | **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) | | |  | | --- | | **10%** | | | | |  | | --- | | **Managing Joe's type 2 Diabetes**  (a year of routine in-network care of a well- controlled condition) | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | |  | | --- | | **The** [**plan's**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) | | |  | | --- | | **$300** | | | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | |  | | --- | | [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | | |  | | --- | | **$50** | | | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | |  | | --- | | **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) | | |  | | --- | | **10%** | | | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | |  | | --- | | **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) | | |  | | --- | | **10%** | | | | |  | | --- | | **Mia's Simple Fracture**  (in-network emergency room visit and follow up  care) | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | |  | | --- | | **The** [**plan's**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) | | |  | | --- | | **$300** | | | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | |  | | --- | | [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) | | |  | | --- | | **$50** | | | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | |  | | --- | | **Hospital (facility)** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) | | |  | | --- | | **10%** | | | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | |  | | --- | | **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) | | |  | | --- | | **10%** | | | |
| |  | | --- | |  | | **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)* | | |  | | |  | | --- | |  | | **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)* | | | |  | | --- | |  | | |  | | |  | | --- | |  | | **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** | | |  | | --- | | **$12,800** | | | |  | | --- | | **In this example, Peg would pay:** | | | | |  | | --- | | *Cost Sharing* | | | | |  | | --- | | Deductibles | | |  | | --- | | $300 | | | Copayments | |  | | --- | | $30 | | | Coinsurance | |  | | --- | | $900 | | | |  | | --- | | *What isn't covered* | | | | Limits or exclusions | |  | | --- | | $50 | | | |  | | --- | | **The total Peg would pay is** | | |  | | --- | | **$1,280** | | | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | **Total Example Cost** | | |  | | --- | | **$7,400** | | | |  | | --- | | **In this example, Joe would pay:** | | | | |  | | --- | | *Cost Sharing* | | | | |  | | --- | | Deductibles | | |  | | --- | | $300 | | | Copayments | |  | | --- | | $300 | | | Coinsurance | |  | | --- | | $400 | | | |  | | --- | | *What isn't covered* | | | | Limits or exclusions | |  | | --- | | $4,300 | | | |  | | --- | | **The total Joe would pay is** | | |  | | --- | | **$5,300** | | | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | **Total Example Cost** | | |  | | --- | | **$1,900** | | | |  | | --- | | **In this example, Mia would pay:** | | | | |  | | --- | | *Cost Sharing* | | | | |  | | --- | | Deductibles | | |  | | --- | | $70 | | | Copayments | |  | | --- | | $300 | | | Coinsurance | |  | | --- | | $0 | | | |  | | --- | | *What isn't covered* | | | | Limits or exclusions | |  | | --- | | $0 | | | |  | | --- | | **The total Mia would pay is** | | |  | | --- | | **$370** | | |

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| |  |  | | --- | --- | | |  | | --- | | Note: These numbers assume the patient does not participate in the [plan's](https://www.healthcare.gov/sbc-glossary/#plan) wellness program. If you participate in the [plan's](https://www.healthcare.gov/sbc-glossary/#plan) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-ASK-BLUE (TTY:711) | | |

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