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| **Summary of Benefits and Coverage**: What this Plan Covers & What You Pay For Covered Services |

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| **Coverage Period: Beginning on or after 06/01/2023** |

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| **Keystone HMO Villanova University** |

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| **Coverage for**: Family | **Plan Type**: HMO |

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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.** |

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|               **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. |

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| **Important Questions** | **Answers** | **Why This Matters:** |
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| **What is the overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** |

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| $0. |

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| See the Common Medical Events chart below for your costs for services this [plan](https://www.healthcare.gov/sbc-glossary/#plan) covers. |

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| **Are there services covered before you meet your** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible)**?** |

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| --- |
| Yes. |

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| 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/>. |

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| **Are there other** [**deductibles**](https://www.healthcare.gov/sbc-glossary/#deductible) **for specific services?** |

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| --- |
| No. |

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| You don't have to meet [deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) for specific services. |

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| **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)**?** |

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| For Referred [providers](https://www.healthcare.gov/sbc-glossary/#provider) $1,500 person / $3,000 family. |

 |

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| 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. |

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| **What is not included in the** [**out-of-pocket limit**](https://www.healthcare.gov/sbc-glossary/#out-of-pocket-limit)**?** |

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| [Premiums](https://www.healthcare.gov/sbc-glossary/#premium) and health care this [plan](https://www.healthcare.gov/sbc-glossary/#plan) doesn't cover. |

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| 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). |

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| **Will you pay less if you use a** [**network provider**](https://www.healthcare.gov/sbc-glossary/#network-provider)**?** |

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| --- |
| 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). |

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| 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. |

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| **Do you need a** [**referral**](https://www.healthcare.gov/sbc-glossary/#referral) **to see a** [**specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)**?** |

 |

|  |
| --- |
| Yes. |

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| This [plan](https://www.healthcare.gov/sbc-glossary/#plan) will pay some or all of the costs to see a [specialist](https://www.healthcare.gov/sbc-glossary/#specialist) for covered services but only if you have a [referral](https://www.healthcare.gov/sbc-glossary/#referral) before you see the [specialist](https://www.healthcare.gov/sbc-glossary/#specialist). |

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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. |

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|  |  | **What You Will Pay** |  |
| --- | --- | --- | --- |
| **Common Medical Event** | **Services You May Need** |

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| --- |
| **Referred Provider****(You will pay the least)** |

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| --- |
| **Out-of-Network Provider (You will pay the most)** |

 | **Limitations, Exceptions, & Other Important Information** |
|

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| --- |
| **If you visit a health care** [**provider's**](https://www.healthcare.gov/sbc-glossary/#provider) **office or clinic** |

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|   |

 | Primary care visit to treat an injury or illness |

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| --- | --- |
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| --- |
| $20/Visit. |

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| --- |
| Not covered. |

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| --- |
| 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. |

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| --- |
| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit |

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| --- |
| $40/Visit. |

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| --- |
| Not covered. |

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| --- |
| PCP [referral](https://www.healthcare.gov/sbc-glossary/#referral) required. 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. |

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| [Preventive care](https://www.healthcare.gov/sbc-glossary/#preventive-care)/[screening](https://www.healthcare.gov/sbc-glossary/#screening)/immunization |

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| --- | --- |
|

|  |
| --- |
| No charge. |

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| --- | --- |
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| --- |
| Not covered. |

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| --- |
| 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. |

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| --- |
| **If you have a test** |

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| --- |
| [Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) (x-ray, blood work) |

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| --- |
| X-Ray: $20/Visit. Blood Work: No charge. |

 |

|  |
| --- |
| Not covered. |

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| --- |
| PCP [referral](https://www.healthcare.gov/sbc-glossary/#referral) required for x-rays. Requisition form required for lab work. |

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| --- |
| Imaging (CT/PET scans, MRIs) |

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| --- |
| $40/Scan. |

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| --- |
| Not covered. |

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| --- |
| PCP [referral](https://www.healthcare.gov/sbc-glossary/#referral) required. Precertification required for certain services. \*See section General Information. |

 |
| **If you need drugs to treat your illness or condition**

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| --- |
| Generic Drugs |

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| --- |
| $10 copay / $25 copay |

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|  |
| --- |
| Submit a direct claim form. |

 |

|  |
| --- |
| None |

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|  |
| --- |
| Preferred Brand |

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| --- |
| $30 copay / $75 copay |

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| --- |
| Submit a direct claim form. |

 |

|  |
| --- |
| None |

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| --- |
| Non Preferred Drugs |

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| --- |
| $50 copay / $125 copay |

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|  |
| --- |
| Submit a direct claim form. |

 |

|  |
| --- |
| None |

 |
| SaveOnSP Specialty Drugs | 30% Coinsurance | Not Covered | Coinsurance for select specialty mediations will equal 30%, unless you enroll in SaveOnSP. The 30% coinsurance does not apply to the deductible or out-of-pocket maximum. If you enrolled in the SaveOnSP program, there is a $0 copay for Specialty drugs on SaveOnSP Specialty Drug List |
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| --- |
| [Specialty Drugs](https://www.healthcare.gov/sbc-glossary/#specialty-drug) |

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| --- |
| $50 copay / prescription fill  |

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| --- |
| Not covered. |

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| --- |
| This benefit 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. |

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| --- |
| **If you have outpatient surgery** |

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|  |
| --- |
| Facility fee (e.g., ambulatory surgery center) |

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|  |
| --- |
| $100/Visit. |

 |

|  |
| --- |
| Not covered. |

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| --- |
| Precertification may be required. \*See section General Information. |

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| --- |
| Physician/surgeon fees |

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|  |  |
| --- | --- |
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| --- |
| No charge. |

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| --- | --- |
|

|  |
| --- |
| Not covered. |

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| --- |
| **If you need immediate medical attention** |

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| --- |
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| --- |
| [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) |

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|  |  |
| --- | --- |
|

|  |
| --- |
| $100/Visit. |

 |

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|  |
| --- |
| Covered at In-Network level. |

 |

|  |
| --- |
| None |

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|

|  |
| --- |
| [Emergency medical transportation](https://www.healthcare.gov/sbc-glossary/#emergency-medical-transportation) |

 |

|  |  |
| --- | --- |
|

|  |
| --- |
| No charge. |

 |

 |

|  |
| --- |
| Covered at In-Network level. |

 |
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|  |
| --- |
| [Urgent care](https://www.healthcare.gov/sbc-glossary/#urgent-care) |

 |

|  |  |
| --- | --- |
|

|  |
| --- |
| $50/Visit. |

 |

 |

|  |
| --- |
| Not covered. |

 |

|  |
| --- |
| 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. |

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| --- |
| **If you have a hospital stay** |

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| --- |
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| --- |
| Facility fee (e.g., hospital room) |

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| --- | --- |
|

|  |
| --- |
| $250/Admission. |

 |

 |

|  |  |
| --- | --- |
|

|  |
| --- |
| Not covered. |

 |

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|  |
| --- |
| Precertification required. |

 |
|

|  |
| --- |
| Physician/surgeon fees |

 |

|  |  |
| --- | --- |
|

|  |
| --- |
| No charge. |

 |

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|  |  |
| --- | --- |
|

|  |
| --- |
| Not covered. |

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| --- |
| **If you need mental health, behavioral health, or substance abuse services** |

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| --- |
|   |

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|  |
| --- |
| Outpatient services |

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|  |  |
| --- | --- |
|

|  |
| --- |
| $20/Visit. |

 |

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|  |  |
| --- | --- |
|

|  |
| --- |
| Not covered. |

 |

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|  |
| --- |
| Precertification required. |

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|

|  |
| --- |
| Inpatient services |

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|  |  |
| --- | --- |
|

|  |
| --- |
| $250/Admission. |

 |

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| --- | --- |
|

|  |
| --- |
| Not covered. |

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|  |
| --- |
| Precertification required. |

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| --- |
| **If you are pregnant** |

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| --- |
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| --- |
| Office visits |

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| --- | --- |
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|  |
| --- |
| $20/Visit. |

 |

 |

|  |  |
| --- | --- |
|

|  |
| --- |
| Not covered. |

 |

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|  |
| --- |
| 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. |

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| --- |
| Childbirth/delivery professional services |

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| --- | --- |
|

|  |
| --- |
| No charge. |

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|  |
| --- |
| Not covered. |

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| --- |
| Childbirth/delivery facility services |

 |

|  |  |
| --- | --- |
|

|  |
| --- |
| $250/Admission. |

 |

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|  |  |
| --- | --- |
|

|  |
| --- |
| Not covered. |

 |

 |

|  |
| --- |
| 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. |

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| --- |
| **If you need help recovering or have other special health needs** |

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| [Home health care](https://www.healthcare.gov/sbc-glossary/#home-health-care) |

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| --- | --- |
|

|  |
| --- |
| No charge. |

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| --- | --- |
|

|  |
| --- |
| Not covered. |

 |

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|  |
| --- |
| Precertification required. |

 |
|

|  |
| --- |
| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) |

 |

|  |
| --- |
| $40/Visit. |

 |

|  |
| --- |
| Not covered. |

 |

|  |
| --- |
| PCP [referral](https://www.healthcare.gov/sbc-glossary/#referral) required. Physical/Occupational Therapies: 30 visits combined/Contract Year. Speech Therapy: 20 visits/Contract Year. |

 |
|

|  |
| --- |
| [Habilitation services](https://www.healthcare.gov/sbc-glossary/#habilitation-services) |

 |

|  |
| --- |
| $40/Visit. |

 |

|  |
| --- |
| Not covered. |

 |

|  |
| --- |
| PCP [referral](https://www.healthcare.gov/sbc-glossary/#referral) required. Physical/Occupational Therapies: 30 visits combined/Contract Year. Speech Therapy: 20 visits/Contract Year. |

 |
|

|  |
| --- |
| [Skilled nursing care](https://www.healthcare.gov/sbc-glossary/#skilled-nursing-care) |

 |

|  |  |
| --- | --- |
|

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| --- |
| $250/Admission. |

 |

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| --- | --- |
|

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| --- |
| Not covered. |

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| --- |
| Precertification required. 120 visits/Contract Year. |

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| --- |
| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) |

 |

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| --- |
| 30% [coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance). |

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| --- |
| Not covered. |

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| --- |
| Precertification required for selected items. \*See section General Information. |

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| --- |
| [Hospice services](https://www.healthcare.gov/sbc-glossary/#hospice-services) |

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| --- |
| No charge. |

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| --- |
| Not covered. |

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| --- |
| Precertification required. |

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| --- |
| **If your child needs dental or eye care** |

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| --- |
| Children's eye exam |

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| --- | --- |
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| --- |
| $40/Visit. |

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| --- | --- |
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|  |
| --- |
| Not covered. |

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|  |
| --- |
| Once every contract year. |

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|

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| --- |
| Children's glasses |

 |

|  |
| --- |
| Covered 100% on all Davis collection. |

 |

|  |
| --- |
| $100 reimbursement. |

 |

|  |
| --- |
| Once every contract year. |

 |
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| --- |
| Children's dental check-up |

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| --- |
| Not covered. |

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|  |
| --- |
| Not covered. |

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| --- |
| 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)**.)** |

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| Cosmetic surgery |

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| Long-term care |

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| Routine foot care |

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| Dental care (Adult) |

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| Non-emergency care when traveling outside the U.S. |

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| Weight loss programs |

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| Hearing aids |

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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.)** |

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| Acupuncture |

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| Chiropractic care |

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| Private-duty nursing |

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| Bariatric surgery |

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| Infertility treatment (covered for artificial insemination and assisted reproductive technology) |

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| Routine eye care (Adult) |

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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, individuals should contact their State Insurance regulator regarding their 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 Pennsylvania [Health Insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) [Marketplace](https://www.healthcare.gov/sbc-glossary/#marketplace), visit [www.Pennie.gov](https://www.Pennie.gov) or call 1-844-844-8040. |

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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 on how 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.**[Minimum Essential Coverage](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage) generally includes [plans](https://www.healthcare.gov/sbc-glossary/#plan), [health insurance](https://www.healthcare.gov/sbc-glossary/#health-insurance) available through the [Marketplace](https://www.healthcare.gov/sbc-glossary/#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](https://www.healthcare.gov/sbc-glossary/#minimum-essential-coverage), you may not be eligible for the [premium tax credit](https://www.healthcare.gov/sbc-glossary/#premium-tax-credits). |

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| **Does this plan meet Minimum Value Standards?** 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). |

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| ***To see examples of how this*** [***plan***](https://www.healthcare.gov/sbc-glossary/#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) |
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| **The** [**plan's**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) |

 |

|  |
| --- |
| **$0** |

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| [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) |

 |

|  |
| --- |
| **$40** |

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| **Hospital (facility)** [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) |

 |

|  |
| --- |
| **$250** |

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| **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) |

 |

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| **0%** |

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| **Managing Joe's type 2 Diabetes**(a year of routine in-network care of a well-controlled condition) |
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| **The** [**plan's**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) |

 |

|  |
| --- |
| **$0** |

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| [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) |

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| --- |
| **$40** |

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| **Hospital (facility)** [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) |

 |

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| --- |
| **$250** |

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| **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) |

 |

|  |
| --- |
| **0%** |

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| **Mia's Simple Fracture**(in-network emergency room visit and follow up care) |
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| **The** [**plan's**](https://www.healthcare.gov/sbc-glossary/#plan) **overall** [**deductible**](https://www.healthcare.gov/sbc-glossary/#deductible) |

 |

|  |
| --- |
| **$0** |

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| [**Specialist**](https://www.healthcare.gov/sbc-glossary/#specialist)[**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) |

 |

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| --- |
| **$40** |

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| **Hospital (facility)** [**copayment**](https://www.healthcare.gov/sbc-glossary/#copayment) |

 |

|  |
| --- |
| **$250** |

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| **Other** [**coinsurance**](https://www.healthcare.gov/sbc-glossary/#coinsurance) |

 |

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| --- |
| **0%** |

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| **This EXAMPLE event includes services like:** |
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| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) office visits *(prenatal care)* |

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| Childbirth/Delivery Professional Services |

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| Childbirth/Delivery Facility Services |

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| [Diagnostic tests](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) *(ultrasounds and blood work)* |

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| [Specialist](https://www.healthcare.gov/sbc-glossary/#specialist) visit *(anesthesia)* |

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|  |
| **This EXAMPLE event includes services like:** |
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| [Primary care physician](https://www.healthcare.gov/sbc-glossary/#primary-care-physician) office visits *(including disease education)* |

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| --- |
| [Diagnostic tests](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) *(blood work)* |

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| --- |
| [Prescription drugs](https://www.healthcare.gov/sbc-glossary/#prescription-drugs) |

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| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) *(glucose meter)* |

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| **This EXAMPLE event includes services like:** |
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| [Emergency room care](https://www.healthcare.gov/sbc-glossary/#emergency-room-care-emergency-services) *(including medical supplies)* |

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| [Diagnostic test](https://www.healthcare.gov/sbc-glossary/#diagnostic-test) *(x-ray)* |

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| [Durable medical equipment](https://www.healthcare.gov/sbc-glossary/#durable-medical-equipment) *(crutches)* |

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| [Rehabilitation services](https://www.healthcare.gov/sbc-glossary/#rehabilitation-services) *(physical therapy)* |

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| --- |
| **Total Example Cost** |

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|  |
| --- |
| **$12,700** |

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|

|  |
| --- |
| **In this example, Peg would pay:** |

 |
|

|  |
| --- |
| *Cost Sharing* |

 |
|

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| --- |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) |

 |

|  |
| --- |
| $0 |

 |
|

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| --- |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) |

 |

|  |
| --- |
| $300 |

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| --- |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |

 |

|  |
| --- |
| $0 |

 |
|

|  |
| --- |
| *What isn't covered* |

 |
| Limits or exclusions |

|  |
| --- |
| $30 |

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|

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| --- |
| **The total Peg would pay is** |

 |

|  |
| --- |
| **$330** |

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| --- |
| **Total Example Cost** |

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|  |
| --- |
| **$5,600** |

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|

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| --- |
| **In this example, Joe would pay:** |

 |
|

|  |
| --- |
| *Cost Sharing* |

 |
|

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| --- |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) |

 |

|  |
| --- |
| $0 |

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|

|  |
| --- |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) |

 |

|  |
| --- |
| $200 |

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|

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| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |

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|  |
| --- |
| $200 |

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|

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| --- |
| *What isn't covered* |

 |
| Limits or exclusions |

|  |
| --- |
| $3,500 |

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|

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| --- |
| **The total Joe would pay is** |

 |

|  |
| --- |
| **$3,900** |

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| **Total Example Cost** |

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|  |
| --- |
| **$2,800** |

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| --- |
| **In this example, Mia would pay:** |

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|  |
| --- |
| *Cost Sharing* |

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| --- |
| [Deductibles](https://www.healthcare.gov/sbc-glossary/#deductible) |

 |

|  |
| --- |
| $0 |

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|

|  |
| --- |
| [Copayments](https://www.healthcare.gov/sbc-glossary/#copayment) |

 |

|  |
| --- |
| $300 |

 |
|

|  |
| --- |
| [Coinsurance](https://www.healthcare.gov/sbc-glossary/#coinsurance) |

 |

|  |
| --- |
| $20 |

 |
|

|  |
| --- |
| *What isn't covered* |

 |
| Limits or exclusions |

|  |
| --- |
| $10 |

 |
|

|  |
| --- |
| **The total Mia would pay is** |

 |

|  |
| --- |
| **$330** |

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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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