



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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.octorara.k12.pa.us or call (610)593-8238. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call (610)593-8238 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	\$300 individual/\$600 family <u>network</u> . \$500 individual/\$1,000 family <u>out-of-network</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	<u>Network deductible</u> does not apply to office visits, <u>preventive care services</u> , outpatient bloodwork, physician/surgeon fees, outpatient mental health, outpatient substance abuse, <u>habilitation services</u> , <u>rehabilitation services</u> , and <u>prescription drug coverage</u> . <u>Copayments</u> and <u>coinsurance</u> amounts don't count toward the <u>network deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Medical- \$4,950 individual/\$9,900 family <u>network maximum out-of-pocket limit</u> . \$7,600 individual/\$15,200 family <u>out-of-network</u> . Drug- \$1,650 individual/\$3,300 family <u>maximum out-of pocket limit</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p><u>Network</u>: <u>Premiums</u>, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover do not apply to your total <u>maximum out-of-pocket limit</u>.</p> <p><u>Out-of-network</u>: <u>Premiums</u>, <u>copayments</u>, <u>deductibles</u>, <u>balance-billing</u> charges, <u>prescription drug expenses</u>, and health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. For a list of <u>network providers</u>, see www.octorara.k12.pa.us or call (610)593-8238.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>).</p> <p>Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do I need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	-----none-----
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	-----none-----
	<u>Preventive care/Screening/Immunization</u>	No charge for <u>preventive care services</u> ; <u>deductible</u> does not apply	30% <u>coinsurance</u> ; <u>deductible</u> does not apply	Age and frequency schedules may apply. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$30 <u>copay</u> /test for x-ray; No charge for bloodwork; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Pre-certification required for certain services. See section General Information in benefit book. 20% reduction in benefits for failure to pre-cert <u>out-of-network</u> or BlueCard services.
	Imaging (CT/PET scans, MRIs)	\$30 <u>copay</u> /test	30% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com .	Generic drugs	\$5 <u>copay</u> /prescription (retail) \$10 <u>copay</u> /prescription (mail order)	Not covered	-----none-----
	Preferred brand drugs	\$35 <u>copay</u> /prescription (retail) \$70 <u>copay</u> /prescription (mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 <u>copay</u> /visit	30% <u>coinsurance</u>	Pre-certification required. See section General Information in benefit book. 20% reduction in benefits for failure to pre-authorize <u>out-of-network</u> outpatient services or treatments.
	Physician/surgeon fees	No charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room Care</u>	\$40 <u>copay</u> /visit	\$40 <u>copay</u> /visit after <u>network deductible</u>	<u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	No charge	No charge after <u>network deductible</u>	-----none-----
	<u>Urgent care</u>	\$28 <u>copay</u> /visit	30% <u>coinsurance</u>	Your costs for <u>urgent</u> care are based on care received at a designated <u>urgent care</u> 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)	\$150 <u>copay</u> /day (maximum 5 <u>copays</u> per admission)	30% <u>coinsurance</u>	Pre-certification required. \$1,000 member penalty for failure to pre-authorize inpatient services or treatment for <u>out-of-network</u> care.
	Physician/surgeon fee	No charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Pre-certification required. \$1,000 member penalty for failure to pre-authorize inpatient services or treatment for <u>out-of-network</u> care.
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	\$30 <u>copay</u> /visit	30% <u>coinsurance</u>	Pre-certification required. 20% reduction in benefits for failure to pre-authorize <u>out-of-network</u> outpatient services or treatments.
	Inpatient services	\$150 <u>copay</u> /day (maximum 5 <u>copays</u> per admission)	30% <u>coinsurance</u>	Pre-certification required. \$1,000 member penalty for failure to pre-authorize inpatient services or treatment for <u>out-of-network</u> care.
If you are pregnant	Office visits	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Office visit cost share applies to the first OB visit only. Depending on the type of services, a <u>deductible</u> , <u>copayment</u> or <u>coinsurance</u> 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	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$150 <u>copay</u> /day (maximum 5 <u>copays</u> per admission)	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	30% <u>coinsurance</u>	Pre-certification required. 20% reduction in benefits for failure to pre-authorize <u>out-of-network</u> outpatient services or treatments.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit (visits 1-30) \$30 <u>copay</u> /visit (visits 31-60); <u>deductible</u> does not apply	30% <u>coinsurance</u>	Pre-certification required. 50% member penalty applies for failure to pre-authorize <u>out-of-network</u> Speech Therapy. Physical therapy, speech therapy, and occupational therapy: 60 visits per year combined.
	<u>Habilitation services</u>	\$20 <u>copay</u> /visit (visits 1-30) \$30 <u>copay</u> /visit (visits 31-60); <u>deductible</u> does not apply	30% <u>coinsurance</u>	Pre-certification required. 50% member penalty applies for failure to pre-authorize <u>out-of-network</u> Speech Therapy. Physical therapy, speech therapy, and occupational therapy: 60 visits per year combined.
	<u>Skilled nursing care</u>	No charge	30% <u>coinsurance</u>	Pre-certification required. \$1,000 member penalty for failure to pre-authorize inpatient services or treatment for <u>out-of-network</u> care. Limit: 120 visits per benefit period.
	<u>Durable medical equipment</u>	\$30 <u>copay</u> /visit	30% <u>coinsurance</u>	Pre-certification required. 20% reduction in benefits for failure to pre-authorize <u>out-of-network</u> outpatient services or treatments
	<u>Hospice service</u>	No charge	30% <u>coinsurance</u>	Pre-certification required. \$1,000 member penalty for failure to pre-authorize inpatient services or treatment for <u>out-of-network</u> care.
If your child needs dental or eye care	Children's Eye exam	Not covered	Not covered	-----none-----
	Children's Glasses	Not covered	Not covered	-----none-----
	Children's Dental check-up	Not covered	Not covered	-----none-----

Excluded Services & Other Covered Services:

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

- Acupuncture
- Hearing aids
- Routine eye care (Adult)
- Cosmetic surgery
- Infertility treatment
- Routine foot care
- Dental care (Adult)
- Long-term care
- Weight loss programs

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

- Bariatric surgery
- Coverage provided outside the United States. See www.bcbsglobalcore.com.
- Non-emergency care when traveling outside the U.S.
- Chiropractic care
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <http://www.HealthCare.gov> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Your plan administrator/employer at (610)593-8238.
- Caremark at 1-800-552-8159.
- Independence Blue Cross at 1-800-275-2583.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have 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.

Does this plan meet the Minimum Value Standards? Yes

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

To obtain language assistance, call (610)593-8238.

SPANISH (Español): Para obtener asistencia en Español, llame al (610)593-8238.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (610)593-8238.

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 (610)593-8238.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (610)593-8238.

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

About these Coverage Examples:



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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$300
- Specialist copayment \$30
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost \$12,800

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$370
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$670

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$300
- Specialist copayment \$30
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost \$7,400

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$1,350
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,650

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$300
- Specialist copayment \$30
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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 \$1,900

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$210
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$510

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact (610)593-8238.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese:

注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어

지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: યુના: જો તમે જુ રાતી બોલતા હો, તો િન: ુ ડ

ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.

1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية

متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf

griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: यान दा: यदि आप िहंदी बोलते ह तो आपके िलए

मुत मा भाषा सहायता सेवाएं उपलब्ध ह। कॉल कर 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese:

備考: 母国語が日本語の方は、言語アシスタンスサービス (無料) をご利用いただけます。

1-800-275-2583へお電話ください。

Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. یا شماره 1-800-275-2583 تماس بگیرید.

Navajo: D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jii'eh. H0d77lnih koj8' 1-800-275-2583.

Urdu:

توجه درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583

Mon-Khmer, Cambodian: សូមមេ្តង ចប់រមមណ៍: ្របសិនេបើអនកនិយយកម្រមន-ែខមរ

ប្រករែខមរ ែន:

ជំនួយជនកកនីធមនផ្តល់ជូនដល់េកអនកេយ គត

គិតថ្លៃ ទូរសពនេទេលេ 1-800-275-25

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.