Central Susquehanna Trust
PPO Plan Prescription Drug Benefit

Prescription Drug Coverage

PPO Plan Prescription Drug Benefit

Retail (1 - 31 day supply):	$50 Deductible* Per Person, Per Calendar Year then services are paid at the following levels:	
	Generic	20% copayment - $25 maximum payment
	Brand Name	25% copayment - $50 maximum payment
	Multi-Source**	30% copayment - $50 maximum payment
Mail Order (32 - 90 day supply):	No Deductible	
	Generic	15% copayment - $15 maximum payment
	Brand Name	25% copayment - $50 maximum payment
	Multi-Source**	30% copayment - $50 maximum payment

*The Deductible is charged at the pharmacy and tracked electronically within the MedcoHealth system.
**Multi-Source brand drugs are those Brand Name drugs that have a Generic equivalent and you obtain the Brand Name drug instead of the Generic

Note: This document is for illustrative purposes only and is not intended to be a complete description of benefits.
These benefit descriptions represent coverages effective January 1, 2012.
Trustees reserve the right to amend the Trust PPO Plan benefits as appropriate.

Capital BLUE

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Benefit Highlights
PPO 0 Plan
Central Susquehanna Trust

SUMMARY OF COST-SHARING	Amounts *Members* Are Responsible For:	
	Participating Providers	*Nonparticipating Providers*
Deductible (per annual benefit period) ***Deductible applies to all services unless a Copayment is applied or otherwise noted***	None	$500 per member $1,000 per family
Copayments		
• Office Visits (Family Practitioner, General Practitioner, Internist, Pediatrician)	$ 20 copayment per visit	30% coinsurance
• Specialist Office Visit	$ 20 copayment per visit	30% coinsurance
• Emergency Room	$ 100 copayment per visit, waived if admitted	
• Urgent Care	$ 50 copayment per visit	30% coinsurance
• Inpatient (Per Admission)	Not Applicable	50% coinsurance
• Outpatient Surgery Copayment (facility)	Not Applicable	50% coinsurance
Coinsurance	Not Applicable	30% coinsurance
Coinsurance Out-of-Pocket Maximum (includes coinsurance amounts) When this amount is satisfied, no further coinsurance is applied.	Not Applicable	$3,000 per member $6,000 per family
Maximum Out-of-Pocket Liability (includes copayment amounts) When this amount is satisfied, there are no further member out-of-pocket costs for services that are provided by *participating providers*.	$3,675 per member $7,350 per family	No maximum. Copayments continue to be your out-of-pocket cost. Also, balance billing by *nonparticipating providers* continues to be your out-of-pocket cost.
Coverage Lifetime Maximum	Unlimited	Unlimited

SUMMARY OF BENEFITS	Limits and Maximums	Amounts *Members* Are Responsible For:	
		Participating Providers	*Nonparticipating Providers*
PREVENTIVE CARE: *Administered in accordance with Preventive Health Guidelines and PA state mandates*			
Preventive Care Services			
• Pediatric Preventive Care		Covered in full, no deductible, no copay	30% coinsurance after deductible
• Adult Preventive Care		Covered in full, no deductible, no copay	30% coinsurance after deductible
Immunizations		Covered in full, no deductible	30% coinsurance, waive deductible
Mammograms			
• Screening Mammogram (age 35 and older)	One per 12 month period	Covered in full, no deductible	30% coinsurance, waive deductible
Gynecological Services			
• Screening Gynecological Exam	One per 12 month period	Covered in full, no deductible, no copay	30% coinsurance, waive deductible
• Screening Pap Smear	One per 12 month period	Covered in full, no deductible	30% coinsurance, waive deductible
BENEFITS LISTED BELOW APPLY ONLY AFTER BENEFIT PERIOD DEDUCTIBLE IS MET			
Acute Care Hospital Room & Board		Covered in full	50% coinsurance after deductible
Acute Inpatient Rehabilitation		Covered in full	50% coinsurance after deductible
Skilled Nursing Facility		Covered in full	50% coinsurance after deductible
Surgery			
• Surgical Procedure		Covered in full	30% coinsurance after deductible
• Anesthesia		Covered in full	30% coinsurance after deductible
Maternity Services and Newborn Care		Covered in full	30% coinsurance after deductible
Diagnostic Services			
• Radiology		Covered in full	30% coinsurance after deductible
• Laboratory		Covered in full	30% coinsurance after deductible
Outpatient Therapy Services			
• Physical Medicine		Copayment per visit	30% coinsurance after deductible
• Occupational Therapy		Copayment per visit	30% coinsurance after deductible
• Speech Therapy		Copayment per visit	30% coinsurance after deductible
• Manipulation Therapy		Copayment per visit	30% coinsurance after deductible
Emergency Services		Covered in full, waive deductible Emergency room copayment applies, waived if admitted	
Medical Transport			
• Emergency Ambulance		Covered in full, waive deductible	
• Non-Emergency Ambulance		Covered in full	30% coinsurance after deductible

SUMMARY OF BENEFITS (CONTINUED)	Limits and Maximums	Amounts Members Are Responsible For:	
		Participating Providers	*Nonparticipating Providers*
Mental Health Care Services • Inpatient Services		Covered in full	30% professional and 50% facility coinsurance after deductible
• Outpatient Services		Copayment per visit	30% professional and 50% facility coinsurance after deductible
Substance Abuse Services • Rehabilitation – Inpatient		Covered in full	30% professional and 50% facility coinsurance after deductible
• Rehabilitation – Outpatient		Copayment per visit	30% professional and 50% facility coinsurance after deductible
Home Health Care Services	90 visits/benefit period	Covered in full	50% coinsurance after deductible
Hospice Care		Covered in full	Not covered
Durable Medical Equipment (DME)		Covered in full	30% coinsurance after deductible
Prosthetic Appliances and Orthotic Devices		Covered in full	30% coinsurance after deductible
Diabetic Supplies and Education		Covered in full	30% coinsurance after deductible

OTHER STANDARD PLAN FEATURES	
Preauthorization	Preauthorization is a clinical program in which our nurses work with physicians to approve and monitor certain health care services prior to the delivery of services. The purpose of Preauthorization is to ensure all members receive medically appropriate treatment to meet their individual needs.
Disease Management	Disease Management Programs are a collaborative process that assess the health needs of a member with a chronic condition and provides education, counseling and on-demand information designed to increase a member's self-management of his/her diabetes, asthma, heart disease, and/or depression.
Nurse Line	Nurse Line is staffed 24 hours a day, 7 days a week by experienced Registered Nurses to provide information and support for any health-related concern. Call 800-452-BLUE.
mycapbluecross.com	Members register for on-line access to their personal account to check claim status, compare hospital quality and treatment costs, print temporary proof of coverage, read the SimplyWell℠ member newsletter, view explanation of benefits, and much more.

STANDARD BENEFIT EXCLUSIONS. The following list highlights ***some*** standard benefit exclusions. It is **NOT** intended to be a complete list or a complete description of all categories of benefit exclusions.

Cosmetic procedures – Acupuncture – Routine foot care – Eyeglasses, contact lenses, or vision examinations for prescribing or fitting eyeglasses or contact lenses – Corneal surgery and other procedures to correct refractive errors – Prescription and over-the-counter drugs dispensed by a pharmacy or home health care agency provider – Hearing aids or examinations for the prescription or fitting of hearing aids – All dental services rendered after stabilization of a member in an emergency following an accidental injury – Treatment of obesity, except for surgical treatment of morbid obesity – Any treatment leading or relating to or in connection with assisted fertilization, including donor services – Certain non-neonatal circumcisions - Procedures to reverse sterilization

THIS IS NOT A CONTRACT. This information highlights ***some*** of the benefits available through this program and is **NOT** intended to be a complete list or complete description of available services.

Inpatient admissions as well as certain other services and equipment may require preauthorization.

Participating providers agree to accept our allowance as payment in full—often less than their normal charge.

If you visit a nonparticipating provider, you are responsible for paying the deductible, coinsurance and the difference between the nonparticipating provider's charges and the allowable amount. Nonparticipating providers may balance bill the member.

For more information or to locate a participating provider, visit www.capbluecross.com.

Contact Capital BlueCross Customer Service Department at 1-866-787-9872 for the applicable benefit period.

Autism Spectrum Disorders are covered as mandated by Pennsylvania state law for group size > 51.

Central Susquehanna Region School Employees' Health and Welfare Trust (Administered by Capital BlueCross[1])

PPO $0 In-Network Deductible Plan

Coverage Period: 1/1/2018 - 12/31/2018

Summary of Benefits and Coverage: What this Plan[2] Covers & What it Costs

Coverage for: All | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at capbluecross.com or by calling 1-866-787-9872. If you want more detail about your prescription drug coverage and costs, you can get the complete terms in the policy or plan document at www.cstrust.org or by calling Express Scripts at 1-800-711-0917.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**/person participating providers **$500**/person/**$1,000**/family non-participating providers. Doesn't apply to emergency services or emergency ambulance.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for non-participating provider covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. $50 annual calendar year **deductible** per person for prescription drugs purchased at Retail Pharmacy. There is no annual deductible for prescription drugs purchased at Mail Order.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Is there an out-of-pocket limit on my expenses?	Coinsurance Maximum: $0 for participating providers; $3,000/person and $6,000/family for non-participating providers. Total Maximum Medical Expenses: $3,675/person and $7,350/family for participating providers. Total Maximum Prescription Drug Expenses: $3,675/person and $7,350/family for participating providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Pre-authorization penalties, premiums, balance-billed charges, and health care the plan does not cover do not apply towards the total out-of-pocket limit.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see capbluecross.com or call 1-800-962-2242.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays for different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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Questions: Call 1-866-787-9872 or visit capbluecross.com For prescription drug questions, call 1-800-711-0917 or visit www.express-scripts.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-866-787-9872 to request a copy

PPO $0 In-Network Deductible Plan

Coverage Period: 1/1/2018 - 12/31/2018

Summary of Benefits and Coverage: What this Plan[2] Covers & What it Costs

Coverage for: All | **Plan Type:** PPO

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a:		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	30% coinsurance	----------none----------
	Specialist visit	$20 copay/visit	30% coinsurance	
	Other practitioner office visit	$20 copay/visit for chiropractic	30% coinsurance for chiropractic	Acupuncture not covered.
	Preventive care / screening / immunization	No charge	30% coinsurance	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	No charge for lab or tests.	30% coinsurance	----------none----------
	Imaging (CT / PET scans, MRIs)	No charge	30% coinsurance	Preauthorization is required.[3]

3 Preauthorization may apply. See your contract for a list of services requiring Preauthorization and penalties for failure to obtain Preauthorization.

PPO $0 In-Network Deductible Plan

Coverage Period: 1/1/2018 - 12/31/2018

Summary of Benefits and Coverage: What this Plan[2] Covers & What it Costs

Coverage for: All | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	20% copayment to a $25 maximum payment for a Retail prescription, 15% copayment to a $15 maximum payment for a Mail Order prescription	20% copayment to a $25 maximum payment for a Retail prescription, 15% copayment to a $15 maximum payment for a Mail Order prescription	Covers up to a 31 day supply (Retail prescription), 90 day supply (Mail Order prescription). Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Brand name drugs with No Generic equivalents	25% copayment to a $50 maximum payment for a Retail prescription; 25% copayment to a $50 maximum payment for a Mail Order prescription	25% copayment to a $50 maximum payment for a Retail prescription; 25% copayment to a $50 maximum payment for a Mail Order prescription	Covers up to a 31 day supply (Retail prescription); 90 day supply (Mail Order prescription). Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Multi-Source brand name drugs with Generic equivalents	30% copayment to a $50 maximum payment for a Retail prescription, 30% copayment to a $50 maximum payment for a Mail Order prescription	30% copayment to a $50 maximum payment for a Retail prescription, 30% copayment to a $50 maximum payment for a Mail Order prescription	Covers up to a 31 day supply (Retail prescription), 90 day supply (Mail Order prescription). Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Specialty drugs	25% copayment to a $50 maximum payment for a Retail prescription; 25% copayment to a $50 maximum payment for a Mail Order prescription	25% copayment to a $50 maximum payment for a Retail prescription; 25% copayment to a $50 maximum payment for a Mail Order prescription	Covers up to a 31 day supply (Retail prescription); 90 day supply (Mail Order prescription). Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% coinsurance	Services at non-participating ambulatory surgical facilities 50% coinsurance.
	Physician / surgeon fees	No charge	30% coinsurance	Preauthorization is required.[3]
If you need immediate medical attention	Emergency room services	$100 copay/service	$100 copay/service	Deductible doesn't apply. Copay waived if admitted inpatient.
	Emergency medical transportation	No charge	No charge	Deductible doesn't apply.
	Urgent care	$50 copay/service	30% coinsurance	Deductible doesn't apply for services at participating providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% coinsurance	Preauthorization is required.[3]
	Physician / surgeon fees	No charge	30% coinsurance	----------none----------

[3] Preauthorization may apply. See your contract for a list of services requiring Preauthorization and penalties for failure to obtain Preauthorization.

PPO $0 In-Network Deductible Plan

Coverage Period: 1/1/2018 - 12/31/2018

Summary of Benefits and Coverage: What this Plan[2] Covers & What it Costs

Coverage for: All | Plan Type: PPO

Common Medical Event	Services You May Need	What You Will Pay		Limitations & Exceptions
		In-Network Participating Provider	Out-of-Network Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/visit	30% coinsurance	----------none----------
	Mental/Behavioral health inpatient services	No charge	50% coinsurance	----------none----------
	Substance use disorder outpatient services	$20 copay/visit	30% coinsurance	----------none----------
	Substance use disorder inpatient services	No charge	50% coinsurance	----------none----------
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	----------none----------
	Delivery and all inpatient services	No charge	50% coinsurance	----------none----------
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	After 90 visits, not covered. Preauthorization is required.[3]
	Rehabilitation services	$20 copay/visit	30% coinsurance	----------none----------
	Habilitation services	$20 copay/visit	30% coinsurance	----------none----------
	Skilled nursing care	No charge	50% coinsurance	----------none----------
	Durable medical equipment	No charge	30% coinsurance	Preauthorization is required on items greater than or equal to $500.[3]
	Hospice service	No charge	Not covered	----------none----------
If your child needs dental or eye care	Eye exam	Not covered	Not covered	----------none----------
	Glasses	Not covered	Not covered	----------none----------
	Dental check-up	Not covered	Not covered	----------none----------

[3] Preauthorization may apply. See your contract for a list of services requiring Preauthorization and penalties for failure to obtain Preauthorization.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Routine eye care
- Dental care
- Hearing aids
- Routine foot care (unless medically necessary)
- Bariatric surgery (unless medically necessary)
- Glasses
- Long-term care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services & your costs for these services.)

- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Infertility
- Private-duty nursing
- Most coverage provided outside the United States.
- See www.bcbs.com/shop-for-health-insurance/coverage-home-and-away.html
- Routine maternity

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-866-787-9872**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Capital BlueCross at 1-866-787-9872 for medical and Express Scripts at 1-800-711-0917 for prescription drug. You may also contact the Pennsylvania Insurance Department at 1-877-881-6388 or www.insurance.pa.gov. If your group is subject to ERISA, you may contact the Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For additional assistance, you may contact the Pennsylvania consumer assistance line at 1-877-881-6388 or ra-in-consumer@state.pa.us.

Language Access Services:

Para obtener asistencia en Espanol, llame al 1-800-962-2242.

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

Coverage Examples

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,365
- **Patient pays** $175

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$25
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$175**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,215
- **Patient pays** $1,185

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits & Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$50
Copays	$1,056
Coinsurance	$0
Limits or exclusions	$79
Total	**$1,185**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

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

2 Member cost share may be reduced by employer participation in an HRA (Health Reimbursement Account), HSA (Health Savings Account), or FSA (Flexible Spending Account).

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Nondiscrimination and Foreign Language Assistance Notice

At Capital BlueCross and our family of companies, our customers and the community we serve are at the heart of everything we do. We know health insurance is complicated, and we're here to make it simple so you can focus on living healthy.

Capital BlueCross and its family of companies comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Capital BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Capital BlueCross provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters or written information in other formats (large print, audio, accessible electronic format, other formats). Capital BlueCross provides free language service 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 Capital BlueCross 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 at Capital BlueCross, P.O. Box 779880, Harrisburg, PA 17177-9880, call 800.417.7842 (TTY: 711), fax, 855.990.9001 or email at CRC@capbluecross.com. You can file a grievance in person or by mail, fax, or email. 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, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

If you, or someone you're helping, has questions about your health plan, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800.962.2242 (TTY: 711).

Spanish—Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de su plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800.962.2242 (TTY: 711).

Chinese—如果您，或是您正在協助的對象，有關於您的健康计划方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話[在此插入数字800.962.2242 (TTY: 711)。

Vietnamese—Nếu qu' vị, hay người mà qu' vị đang giúp đỡ, có câu hỏi về chương trình bảo hiểm sức khỏe của bạn, qu' vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800.962.2242 (TTY: 711).

Russian—Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Планирование Вашего здоровья, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 800.962.2242 (TTY: 711).

Pennsylvanian Dutch—"Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut dye zunheit, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 800.962.2242 uffrufe (TTY: 711).

Korean—만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 귀하의 건강보험 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는800.962.2242 (TTY: 711) 로 전화하십시오.

Italian—Se tu o qualcuno che stai aiutando avete domande su plan di il tuo programma sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 800.962.2242 (TTY: 711).

Arabic—

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص لخطة الصحية الخاصة بك ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 800.962.2242 (TTY: 711).

French—Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de votre programme de santé, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800.962.2242 (TTY: 711).

German—Falls Sie oder jemand, dem Sie helfen, Fragen zum durch Ihre Krankenversicherung haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

Gujarati—જો તમને, અથવા કોઈ તમને મદદ કરી રહ્યું છે, તેમને તમારા આરોગ્યના આયોજન અંગે પ્રશ્નો છે, તો તમને કોઈ પણ ખર્ચ વિના મદદ મેળવવાનો અને તમારી ભાષામાં માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા, કૃપયા 800.962.2242 (TTY: 711) પર કોલ કરો.

Polish—Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Twojego ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 800.962.2242 (TTY: 711).

French Creole—Si oumenm oswa yon moun w ap ede gen kesyon konsènan plan sante w, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 800.962.2242 (TTY: 711).

Cambodian-Mon-Khmer—ប្រសិនបើអ្នក ឬនរណាម្នក កំដែលអ្នកកំពុងដែជួយ ម្ននសំណួ រអ្ំពី គម្រោងសុខភាពរបស់អ្នក េ, អ្នកម្ននសិេធិេេលដំនួយនិងព័ែ៌មន ជៅកនុងភា សា រស់អ្នក ជោយមិនអ្ស់ប្ថក ។ ប្បេមបីនិយាយជាមួយអ្នកកដប្ រ សូម 800.962.2242 (TTY: 711) ។

Portuguese—Se você, ou alguém a quem você está ajudando, tem perguntas sobre o o seu plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 800.962.2242 (TTY: 711).