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.highmarkblueshield.com or call 1-866-763-9474. 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 1-800-318-2596 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,500 individual/$3,000 family in-network. $2,250 individual/$4,500 family out-of-network. HRA Hershey contributions: $500/$1,000/$1,500 by tier of coverage	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. Does not apply to copays, prescription drugs and services listed below as "No Charge"
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your network deductible. Copayments and coinsurance amounts don't count toward the network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $2,200 individual / $4,400 family $4,400 individual/$8,800 family out-of-network.	The 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out–of–pocket limit?	Network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-network: Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of network providers, see www.highmarkblueshield.com or call 1-866-763-9474. For pharmacy **network providers**, see www.express-scripts.com or call 1-877-309-6408.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information. Out-of-network: Not subject to deductible.
	Specialist visit	10% coinsurance	30% coinsurance	
	Preventive care/Screening/Immunization	No charge for preventive care services	30% coinsurance for preventive care services	

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	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Precertification may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-877-309-6408.	Generic drugs	20% coinsurance	Not covered	There is a separate out-of-pocket limit for prescription drugs: $1,500/person $3,000/family network There may be a separate ancillary fee if you purchase a brand drug that is not specified by your doctor when a generic drug is available.
	Brand drugs	40% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Network Provider for anesthesia: After deductible, plan pays 90% Precertification may be required.
If you need immediate medical attention	Emergency room Care	10% coinsurance	10% coinsurance	Out-of-network: Subject to network deductible.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Out-of-network: Subject to network deductible.
	Urgent care	10% coinsurance	10% coinsurance	Out-of-network: Subject to network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Precertification may be required.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	Network Provider for anesthesia: After deductible, plan pays 90% Precertification may be required.

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 mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Precertification may be required.
	Inpatient services	10% coinsurance	30% coinsurance	Precertification may be required.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	

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	Home health care	10% coinsurance	30% coinsurance	Combined network and out-of-network: 120 visits per person per benefit period. Precertification may be required.
	Rehabilitation services	10% coinsurance	30% coinsurance	Combined network and out-of-network: 30 physical medicine visits, 30 speech therapy visits, and 30 occupational therapy visits per person per benefit period. Precertification may be required.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	10% coinsurance	30% coinsurance	Precertification may be required.
	Durable medical equipment	10% coinsurance	30% coinsurance	Precertification may be required.
	Hospice service	10% coinsurance	30% coinsurance	Precertification may be required.
If your child needs dental or eye care	Children's Eye exam	No charge	30% coinsurance	One routine eye exam every 24 months.
	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
- Cosmetic surgery
- Dental care (Adult) – This may be provided through separate dental plan (if enrolled)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) – This may be provided through separate vision plan (if enrolled)
- Routine foot care
- Private-duty nursing
- 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
- Chiropractic care
- Coverage provided outside the United States. See http://www.bcbsa.com
- Infertility treatment

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. The Pennsylvania Department of Consumer Services at 1-877-881-6388. 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.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-763-9474 or 1-877-309-6408
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-763-9474 or 1-877-309-6408
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-866-763-9474 or 1-877-309-6408
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-763-9474 or 1-877-309-6408

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	$1,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles (Less $500 HRA Seed)	$1,000
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,760**

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

The plan's overall deductible	$1,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles (Less $500 HRA Seed)	$1,000
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

The plan's overall deductible	$1,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles (Less $500 HRA Seed)	$1,000
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you are an active employee participating in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: HR Support Center, 1-800-878-0440.

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.highmarkblueshield.com or call 1-866-763-9474. 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 1-800-318-2596 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,750 individual/$3,500 family in-network. $3,500 individual/$5,850 family out-of-network. HRA Hershey contributions: $300/$600/$900 by tier of coverage	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. Does not apply to copays, prescription drugs and services listed below as "No Charge"
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your network deductible. Copayments and coinsurance amounts don't count toward the network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $3,000 individual / $6,000 family $6,000 individual/$12,000 family out-of-network.	The 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out–of–pocket limit?	Network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-network: Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of network providers, see www.highmarkblueshield.com or call 1-866-763-9474. For pharmacy **network providers**, see www.express-scripts.com or call 1-877-309-6408.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information. Out-of-network: Not subject to deductible.
	Specialist visit	30% coinsurance	50% coinsurance	
	Preventive care/Screening/Immunization	No charge for preventive care services	50% coinsurance for preventive care services	
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Precertification may be required.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-877-309-6408.	Generic drugs	20% coinsurance	Not covered	There is a separate out-of-pocket limit for prescription drugs: $1,500/person $3,000/family network There may be a separate ancillary fee if you purchase a brand drug that is not specified by your doctor when a generic drug is available.
	Brand drugs	40% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Precertification may be required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Network Provider for anesthesia: After deductible, plan pays 70% Precertification may be required.
If you need immediate medical attention	Emergency room Care	30% coinsurance	30% coinsurance	Out-of-network: Subject to network deductible.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Out-of-network: Subject to network deductible.
	Urgent care	30% coinsurance	30% coinsurance	Out-of-network: Subject to network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Precertification may be required.
	Physician/surgeon fee	30% coinsurance	50% coinsurance	Network Provider for anesthesia: After deductible, plan pays 70% Precertification may be required.

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 mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	Precertification may be required.
	Inpatient services	30% coinsurance	50% coinsurance	Precertification may be required.
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	

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	Home health care	30% coinsurance	50% coinsurance	Combined network and out-of-network: 120 visits per person per benefit period. Precertification may be required.
	Rehabilitation services	30% coinsurance	50% coinsurance	Combined network and out-of-network: 30 physical medicine visits, 30 speech therapy visits, and 30 occupational therapy visits per person per benefit period. Precertification may be required.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	30% coinsurance	50% coinsurance	Precertification may be required.
	Durable medical equipment	30% coinsurance	50% coinsurance	Precertification may be required.
	Hospice service	30% coinsurance	50% coinsurance	Precertification may be required.
If your child needs dental or eye care	Children's Eye exam	No charge	50% coinsurance	One routine eye exam every 24 months.
	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
- Cosmetic surgery
- Dental care (Adult) – This may be provided through separate dental plan (if enrolled)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) – This may be provided through separate vision plan (if enrolled)
- Routine foot care
- Private-duty nursing
- 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
- Chiropractic care
- Coverage provided outside the United States. See http://www.bcbsa.com
- Infertility treatment

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. The Pennsylvania Department of Consumer Services at 1-877-881-6388. 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.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

Language Access Services:
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Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-763-9474 or 1-877-309-6408
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-866-763-9474 or 1-877-309-6408
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-763-9474 or 1-877-309-6408

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	$1,750
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles (Less $300 HRA Seed)	$1,450
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,760**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,750
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles (Less $300 HRA Seed)	$1,450
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,720**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,750
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles (Less $300 HRA Seed)	$1,450
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,750**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you are an active employee participating in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: HR Support Center, 1-800-878-0440.

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

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.highmarkblueshield.com or call 1-866-763-9474. 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 1-800-318-2596 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,750 individual/$3,500 family in-network. $3,500 individual/$5,850 family out-of-network. HRA Hershey contributions: $300/$600/$900 by tier of coverage	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. Does not apply to copays, prescription drugs and services listed below as "No Charge"
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your network deductible. Copayments and coinsurance amounts don't count toward the network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $3,000 individual / $6,000 family $6,000 individual/$12,000 family out-of-network.	The 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-network: Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. For a list of network providers, see www.highmarkblueshield.com or call 1-866-763-9474. For pharmacy **network providers,** see www.express-scripts.com or call 1-877-309-6408.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% coinsurance	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information. Out-of-network: Not subject to deductible.
	Specialist visit	30% coinsurance	50% coinsurance	
	Preventive care/Screening/Immunization	No charge for preventive care services	50% coinsurance for preventive care services	
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Precertification may be required.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-877-309-6408.	Generic drugs	20% coinsurance	Not covered	There is a separate out-of-pocket limit for prescription drugs: $1,500/person $3,000/family network There may be a separate ancillary fee if you purchase a brand drug that is not specified by your doctor when a generic drug is available.
	Brand drugs	40% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Precertification may be required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	Network Provider for anesthesia: After deductible, plan pays 70% Precertification may be required.
If you need immediate medical attention	Emergency room Care	30% coinsurance	30% coinsurance	Out-of-network: Subject to network deductible.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Out-of-network: Subject to network deductible.
	Urgent care	30% coinsurance	30% coinsurance	Out-of-network: Subject to network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Precertification may be required.
	Physician/surgeon fee	30% coinsurance	50% coinsurance	Network Provider for anesthesia: After deductible, plan pays 70% Precertification may be required.

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 mental health, behavioral health, or substance abuse services	Outpatient services	30% coinsurance	50% coinsurance	Precertification may be required.
	Inpatient services	30% coinsurance	50% coinsurance	Precertification may be required.
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	

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	Home health care	30% coinsurance	50% coinsurance	Combined network and out-of-network: 120 visits per person per benefit period. Precertification may be required.
	Rehabilitation services	30% coinsurance	50% coinsurance	Combined network and out-of-network: 30 physical medicine visits, 30 speech therapy visits, and 30 occupational therapy visits per person per benefit period. Precertification may be required.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	30% coinsurance	50% coinsurance	Precertification may be required.
	Durable medical equipment	30% coinsurance	50% coinsurance	Precertification may be required.
	Hospice service	30% coinsurance	50% coinsurance	Precertification may be required.
If your child needs dental or eye care	Children's Eye exam	No charge	50% coinsurance	One routine eye exam every 24 months.
	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
- Cosmetic surgery
- Dental care (Adult) – This may be provided through separate dental plan (if enrolled)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) – This may be provided through separate vision plan (if enrolled)
- Routine foot care
- Private-duty nursing
- 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
- Chiropractic care
- Coverage provided outside the United States. See http://www.bcbsa.com
- Infertility treatment

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. The Pennsylvania Department of Consumer Services at 1-877-881-6388. 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.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-763-9474 or 1-877-309-6408

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-763-9474 or 1-877-309-6408

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-763-9474 or 1-877-309-6408

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-763-9474 or 1-877-309-6408

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	$1,750
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles (Less $300 HRA Seed)	$1,450
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,760**

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

The plan's overall deductible	$1,750
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles (Less $300 HRA Seed)	$1,450
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,720**

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

The plan's overall deductible	$1,750
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles (Less $300 HRA Seed)	$1,450
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,750**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you are an active employee participating in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: HR Support Center, 1-800-878-0440.

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

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.highmarkblueshield.com or call 1-866-763-9474. 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 1-800-318-2596 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,750 individual/$3,500 family in-network. $3,500 individual/$7,000 family out-of-network. HSA Hershey contributions: $750/$1,500/$2,000 by tier of coverage	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. Does not apply to services listed below as "No Charge"
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your network deductible. Copayments and coinsurance amounts don't count toward the network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $2,500 individual/$5,000 family out-of-pocket limit. $5,000 individual/$10,000 famiy out-of-network.	The 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, the overall family out-of-pocket limit must be met.
What is not included in the out–of–pocket limit?	Network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-network: Copayments, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. For a list of network providers, see www.highmarkblueshield.com or call 1-866-763-9474. For a list of pharmacy **network providers**, see www.express-scripts.com or call 1-877-309-6408.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information. Out-of-network: Not subject to deductible.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/Screening/Immunization	No charge for preventive care services	40% coinsurance for preventive care services	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Precertification may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Precertification may be required.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-877-309-6408.	Generic drugs	20% coinsurance	Not covered	Combined medical and prescription deductible: $1,750 individual/$3,500 family in network, $3,500 individual/$7,000 family out-of-network Generic: Pay 100% of discounted drug price until deductible is met. 20% coinsurance after plan deductible is met. Brand: Pay 100% of discounted drug price until deductible is met. 40% coinsurance after plan deductible is met. There may be a separate ancillary fee if you purchase a brand drug that is not specified by your doctor when a generic drug is available.
	Brand drugs	40% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Network Provider for anesthesia: After deductible, plan pays 80% Precertification may be required.
If you need immediate medical attention	Emergency room Care	20% coinsurance	20% coinsurance	Out-of-network: Subject to network deductible.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network: Subject to network deductible.
	Urgent care	20% coinsurance	20% coinsurance	Out-of-network: Subject to network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification may be required.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Network Provider for anesthesia: After deductible, plan pays 80% Precertification may be required.

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 mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Precertification may be required.
	Inpatient services	20% coinsurance	40% coinsurance	Precertification may be required.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

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	Home health care	20% coinsurance	40% coinsurance	Combined network and out-of-network: 120 visits per person per benefit period. Precertification may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Combined network and out-of-network: 90 combined visits for physical medicine, speech therapy, and occupational therapy per person per benefit period.. Precertification may be required.
	Habilitation services	Not covered	Not covered	----------none----------
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Precertification may be required.
	Hospice service	20% coinsurance	40% coinsurance	Precertification may be required.
If your child needs dental or eye care	Children's Eye exam	No charge	40% coinsurance	One routine eye exam every 24 months.
	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
- Cosmetic surgery
- Dental care (Adult) – This may be provided through separate dental plan (if enrolled)
- Hearing aids
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- Non-emergency care when traveling outside the U.S.
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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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:

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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.

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

The plan's overall deductible	$1,750
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles (Less $750 HSA Seed)	$1,000
Copayments	$0
Coinsurance	$750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,810**

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

The plan's overall deductible	$1,750
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles (Less $750 HSA Seed)	$350
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$370**

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

The plan's overall deductible	$1,750
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles (Less $750 HSA Seed)	$1,000
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you are an active employee participating in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: HR Support Center, 1-800-878-0440.

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