

 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, go to <https://www.capbluecross.com/sbcsia> or call 1-800-730-7219. 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](http://www.healthcare.gov/sbc-glossary) or call 1-800-730-7219 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$9,200/Individual, \$18,400/Family. <a href="#">Deductible</a> applies to most services, including <a href="#">prescription drugs</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Professional services with copays, or in-network <a href="#">preventive services</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the annual <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$75 for pediatric dental. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these <a href="#">services</a> .
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$9,200/Individual, \$18,400/Family. Combined <a href="#">out-of-pocket-limit</a> for medical and <a href="#">prescription drug</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. For a list of <a href="#">in-network providers</a> , see <a href="http://capitalbluecross.com">capitalbluecross.com</a> or call 1-800-730-7219.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No Charge	Not Covered	<a href="#">Deductible</a> does not apply to first four PCP visits.
	<a href="#">Specialist</a> visit	No Charge	Not Covered	None
	<a href="#">Preventive care/screening</a> /immunization	No Charge	Not Covered	<a href="#">Deductible</a> does not apply to services at <a href="#">in-network providers</a> . You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge for Facility Owned labs, No Charge for Independent Labs and No Charge for tests. No Charge for outpatient radiology.	Not Covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	*See <a href="#">preauthorization</a> schedule attached to your plan document.
<b>If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available by calling 1-800-730-7219</b>	Generic drugs	No Charge preferred and No Charge non-preferred (retail) No Charge preferred and No Charge non-preferred (home delivery)		Covers up to a 30-day supply (retail) 90-day supply (home delivery).
	Preferred brand drugs	No Charge (retail) No Charge (home delivery)		Covers up to a 30-day supply (retail) 90-day supply (home delivery).
	Non Preferred brand drugs	No Charge (retail) No Charge (home delivery)		Covers up to a 30-day supply (retail) 90-day supply (home delivery).
	<a href="#">Specialty drugs</a>	No Charge preferred and No Charge non-preferred (generic) No Charge preferred and No Charge non-preferred (brand)		Prescription written for up to 30 days supply. (generic) (brand)
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	*See <a href="#">preauthorization</a> schedule attached to your plan document.

\*For more information about preauthorization, see the requirements document at <https://www.capbluecross.com/preauthorization>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need immediate medical attention	<a href="#">Emergency room care</a>	No Charge	No Charge	None
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge	None
	<a href="#">Urgent care</a>	No Charge	No Charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	*See <a href="#">preauthorization</a> schedule attached to your plan document.
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Not Covered	*See <a href="#">preauthorization</a> schedule attached to your plan document.
	Inpatient services	No Charge	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply.
	Childbirth/delivery professional services	No Charge	Not Covered	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply.
	Childbirth/delivery facility services	No Charge	Not Covered	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No Charge	Not Covered	*See <a href="#">preauthorization</a> schedule attached to your plan document.
	<a href="#">Rehabilitation services</a>	No Charge	Not Covered	Visit limits per benefit period: 30 visits combined for physical and occupational therapy; 30 visits for speech therapy. (Visit limits not applicable to mental health care and substance use disorder services.)
	<a href="#">Habilitation services</a>	No Charge	Not Covered	Visit limits per benefit period: 30 visits combined for physical and occupational therapy; 30 visits for speech therapy. (Visit limits not applicable to mental health care and substance use disorder services.)

\*For more information about preauthorization, see the requirements document at <https://www.capbluecross.com/preauthorization>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	<a href="#">Skilled nursing care</a>	No Charge	Not Covered	120 day limit per benefit period. (Limit not applicable to mental health care and substance use disorder services.)
	<a href="#">Durable medical equipment</a>	No Charge	Not Covered	*See <a href="#">preauthorization</a> schedule attached to your plan document.
	<a href="#">Hospice services</a>	No Charge	Not Covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Balance of retail charge after \$32 allowance	One exam and one pair of glasses once every 12 months based on last date of service.
	Children's glasses	No Charge for standard frames and lenses. See <a href="#">plan</a> document for non-standard frame benefits.	Balance of retail charge after frames and lens allowance. See <a href="#">plan</a> document.	One exam and one pair of glasses once every 12 months based on last date of service.
	Children's dental check-up	No Charge	20% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply

\*For more information about preauthorization, see the requirements document at <https://www.capbluecross.com/preauthorization>.

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)	• Hearing aids	• Routine eye care (Adult)
• Bariatric surgery	• Long-term care	• Routine foot care (unless medically necessary)
• Cosmetic Surgery	• Non-emergency care when traveling outside the U.S.	• Weight loss programs
• Dental care (Adult)	• Private-duty nursing	

  

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
• Acupuncture	• Chiropractic care	• 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: 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Pennsylvania Insurance Department at 1-877-881-6388. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [pennie.com](http://pennie.com) or call 1-844-844-8040.

**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: the Pennsylvania Insurance Department at 1-877-881-6388.

**Does this plan provide Minimum Essential Coverage?      Yes**

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

**Does this plan meet Minimum Value Standards?      Not Applicable**

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

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](#) **\$9,200**
- [Specialist coinsurance](#) **0%**
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$9,200
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$9,200</b>

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

- The [plan's](#) overall [deductible](#) **\$9,200**
- [Specialist coinsurance](#) **0%**
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$5,400
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$5,400</b>

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

- The [plan's](#) overall [deductible](#) **\$9,200**
- [Specialist coinsurance](#) **0%**
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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

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**Capital Blue Cross**  
PO Box 779880, Harrisburg, PA 17177-9880  
800.417.7842 (TTY: 711), fax: 855.990.9001  
**CRC@capbluecross.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, D.C. 20201, Toll-free 800.368.1019, 800.537.7697 (TDD). Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

### Language assistance

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).

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Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).

Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).

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무료 전화 통역 서비스 800.962.2242 (TTY: 711).

Per parlare con un interprete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711)

للتحدث مجاناً إلى مترجم للغتك، يرجى الاتصال بـ 800.962.2242 (الهاتف النصي: 711)

Pour parler à un interprète dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).

Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

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Aby porozmawiac z tłumaczem w języku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY: 711)

Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 800.962.2242 (TTY: 711).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711)

Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).

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