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 or call 1-800-730-7219 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,400/Individual, $4,800/Family preferred in-network providers; $4,800/Individual, $9,600/Family non-preferred in-network providers; $5,000/Individual, $10,000/Family out-of-network providers. Deductible applies to most services, including prescription drugs.	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.
Are there services covered before you meet your deductible?	Yes. Professional services with copays, in-network preventive services.	This plan covers some items and services even if you haven't yet met the annual 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?	Yes. $75 for pediatric dental. There are no other specific deductibles.	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.
What is the out-of-pocket limit for this plan?	For in-network providers $8,550 Individual / $17,100 Family; for out-of-network providers $10,000 Individual / $20,000/Family. Combined out-of-pocket limit for network medical and prescription drug.	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?	Premiums, balance billing 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 in-network providers, see capitalbluecross.com or call 1-800-730-7219.	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 you 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 **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-network Provider (You will pay the least)	Non-Preferred In-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	$25 copayment/Visit, Deductible does not apply	$50 copayment/Visit, Deductible does not apply	50% coinsurance	None
	Specialist visit	$50 copayment/Visit, Deductible does not apply	$75 copayment/Visit, Deductible does not apply	50% coinsurance	None
	Preventive care/screening/immunization	No Charge	No Charge	50% coinsurance	Deductible does not apply to services at in-network providers. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (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.	30% coinsurance for Facility Owned labs, 30% coinsurance for Independent Labs and 30% coinsurance for tests. 30% coinsurance for outpatient radiology.	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge	30% coinsurance	50% coinsurance	*See preauthorization schedule attached to your plan document.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available by calling 1-800-730-7219**	Generic drugs	$10 copayment/prescription, Deductible does not apply preferred and 25% coinsurance/prescription, Deductible does not apply non-preferred (retail) $25 copayment/prescription, Deductible does not apply preferred and 25% coinsurance/prescription, Deductible does not apply non-preferred (home delivery)			$250 maximum copayment(retail); $500 maximum copayment(home delivery) for non-preferred generic. Covers up to a 30-day supply (retail) 90-day supply (home delivery).
	Preferred brand drugs	$25 copayment/prescription (retail) $63 copayment/prescription (home delivery)			Covers up to a 30-day supply (retail) 90-day supply (home delivery).
	Non Preferred brand drugs	$75 copayment/prescription (retail) $188 copayment/prescription (home delivery)			Covers up to a 30-day supply (retail) 90-day supply (home delivery).
	Specialty drugs	40% coinsurance/prescription preferred and			Prescription written for up to 30 days

*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
		Preferred In-network Provider (You will pay the least)	Non-Preferred In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
		40% coinsurance/prescription non-preferred (generic) 40% coinsurance/prescription preferred and 40% coinsurance/prescription non-preferred (brand)			supply. / $800 maximum copayment/prescription preferred and $1,000 maximum copayment/prescription non-preferred (generic) / $800 maximum copayment/prescription preferred and $1,000 maximum copayment/prescription non-preferred (brand)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge Acute Care Hospital and No Charge Ambulatory Surgical Center	30% coinsurance Acute Care Hospital and 30% coinsurance Ambulatory Surgical Center	50% coinsurance	No coverage for services at out-of-network ambulatory surgical facilities
	Physician/surgeon fees	No Charge	30% coinsurance	50% coinsurance	*See preauthorization schedule attached to your plan document.
If you need immediate medical attention	Emergency room care	$250 copayment/Visit	$250 copayment/Visit	$250 copayment/Visit	Copayment waived if admitted inpatient.
	Emergency medical transportation	No Charge	No Charge	No Charge	None
	Urgent care	$75 copayment/Visit, Deductible does not apply	$75 copayment/Visit, Deductible does not apply	$75 copayment/Visit, Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	30% coinsurance	50% coinsurance	*See preauthorization schedule attached to your plan document.
	Physician/surgeon fees	No Charge	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: $25 copayment/Visit, Deductible does not apply ; all other outpatient services: No Charge	Outpatient office visits: $25 copayment/Visit, Deductible does not apply ; all other outpatient services: No Charge	50% coinsurance	None
	Inpatient services	No Charge	No Charge	50% coinsurance	None
If you are pregnant	Office visits	$50 copayment/Visit,	$75 copayment/Visit,	50% coinsurance	Depending on the type of services, a

*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
		Preferred In-network Provider (You will pay the least)	Non-Preferred In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
		Deductible does not apply	Deductible does not apply		copayment, coinsurance or deductible may apply.
	Childbirth/delivery professional services	No Charge	30% coinsurance	50% coinsurance	Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery facility services	No Charge	30% coinsurance	50% coinsurance	Depending on the type of services, a copayment, coinsurance or deductible may apply.
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance	50% coinsurance	60 visits limit per benefit period. (Visit limits not applicable to mental health care and substance use disorder services.) *See preauthorization schedule attached to your plan document.
	Rehabilitation services	$50 copayment/Visit, Deductible does not apply	$75 copayment/Visit, Deductible does not apply	50% coinsurance	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.)
	Habilitation services	$50 copayment/Visit, Deductible does not apply	$75 copayment/Visit, Deductible does not apply	50% coinsurance	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.)
	Skilled nursing care	No Charge	30% coinsurance	50% coinsurance	120 day limit per benefit period. (Limit not applicable to mental health care and substance use disorder services.)
	Durable medical	No Charge	30% coinsurance	Not Covered	*See preauthorization schedule

*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
		Preferred In-network Provider (You will pay the least)	Non-Preferred In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	equipment				attached to your plan document.
	Hospice services	No Charge	30% coinsurance	50% coinsurance	None
If your child needs dental or eye care	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 plan document for non-standard frame benefits.		Balance of retail charge after frames and lens allowance. See plan 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% coinsurance	Deductible 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Bariatric surgery
- Cosmetic Surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (unless medically necessary)
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S.

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 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 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	$2,400
Specialist copayment	$50
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,460**

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

The plan's overall deductible	$2,400
Specialist copayment	$50
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,400
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,100**

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

The plan's overall deductible	$2,400
Specialist copayment	$50
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,100
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

[1]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

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If you believe that Capital Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email at:

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).
欲免费用本国语言洽询传译员，请拨电话 800.962.2242 (TTY: 711).
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).
Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).
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 مجانًا إلى مترجم للغتك، يرجى الاتصال بـ 800.962.2242 (الهاتف النصي: 711)
Pour parler à un interpréter 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).
ક્રુભા ષીયા જોડે વાત કરવા , 800.962.2242 (TTY: 711) પર ફોન કરો.
Aby porozmawiac z tlumaczem w jezyku 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).
ដើម្បីនិយាយជាមួយអ្នកបកប្រែភាសាមាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ 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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