

 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>	\$5,950/Individual, \$11,900/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, 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>	\$9,100/Individual, \$18,200/Family. Combined <a href="#">out-of-pocket limit</a> for <a href="#">network</a> 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>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</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)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply	Not Covered	None
	<a href="#">Specialist</a> visit	\$60 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge for Facility Owned labs, No Charge for Independent Labs and 20% <a href="#">coinsurance</a> for tests. 20% <a href="#">coinsurance</a> for outpatient radiology.	Not Covered	None
	Imaging (CT/PET scans, MRIs)	35% <a href="#">coinsurance</a>	Not Covered	*See <a href="#">preauthorization</a> schedule attached to your plan document.
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	Generic drugs	\$10 <a href="#">copayment</a> /prescription, <a href="#">Deductible</a> does not apply preferred and 25% <a href="#">coinsurance</a> /prescription, <a href="#">Deductible</a> does not apply non-preferred (retail) \$25 <a href="#">copayment</a> /prescription, <a href="#">Deductible</a> does not apply preferred and 25% <a href="#">coinsurance</a> /prescription, <a href="#">Deductible</a> 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	\$50 <a href="#">copayment</a> /prescription (retail) \$125 <a href="#">copayment</a> /prescription (home delivery)		Covers up to a 30-day supply (retail) 90-day supply (home delivery).
	Non Preferred brand drugs	\$100 <a href="#">copayment</a> /prescription (retail) \$250 <a href="#">copayment</a> /prescription (home delivery)		Covers up to a 30-day supply (retail) 90-day supply (home delivery).
	<a href="#">Specialty drugs</a>	50% <a href="#">coinsurance</a> /prescription preferred and 50% <a href="#">coinsurance</a> /prescription non-preferred (generic)		Prescription written for up to 30 days supply. / \$800 maximum

\*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)	
		50% <a href="#">coinsurance</a> /prescription preferred and 50% <a href="#">coinsurance</a> /prescription non-preferred (brand)		<a href="#">copayment</a> /prescription preferred and \$800 maximum <a href="#">copayment</a> /prescription non-preferred (generic) / \$800 maximum <a href="#">copayment</a> /prescription preferred and \$1,000 maximum <a href="#">copayment</a> /prescription non-preferred (brand)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	Not Covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not Covered	*See <a href="#">preauthorization</a> schedule attached to your plan document.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$400 <a href="#">copayment</a> /Visit	\$400 <a href="#">copayment</a> /Visit	<a href="#">Copayment</a> waived if admitted inpatient.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Coinsurance</a> waived for mental health and substance use disorder services.
	<a href="#">Urgent care</a>	\$100 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply	\$100 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	Not Covered	*See <a href="#">preauthorization</a> schedule attached to your plan document.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: \$30 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply; all other outpatient services: 20% <a href="#">coinsurance</a>	Not Covered	None
	Inpatient services	20% <a href="#">coinsurance</a>	Not Covered	None
If you are pregnant	Office visits	\$60 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply	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	20% <a href="#">coinsurance</a>	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	20% <a href="#">coinsurance</a>	Not Covered	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a>

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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)	
				may apply.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	Not Covered	60 visits limit per benefit period. (Visit limits not applicable to mental health care and substance use disorder services.) *See <a href="#">preauthorization</a> schedule attached to your plan document.
	<a href="#">Rehabilitation services</a>	\$60 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply	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>	\$60 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply	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="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	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>	20% <a href="#">coinsurance</a>	Not Covered	*See <a href="#">preauthorization</a> schedule attached to your plan document.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	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
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 [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](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](#) **\$5,950**
- [Specialist copayment](#) **\$60**
- 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$5,950
Copayments	\$20
Coinsurance	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$7,270</b>

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

- The [plan's](#) overall [deductible](#) **\$5,950**
- [Specialist copayment](#) **\$60**
- 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$4,200
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$30
<b>The total Joe would pay is</b>	<b>\$4,630</b>

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

- The [plan's](#) overall [deductible](#) **\$5,950**
- [Specialist copayment](#) **\$60**
- 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$2,100
Copayments	\$400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,500</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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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).

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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).

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 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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