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.cciio.cms.gov or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 individual / $500 family participating providers; $5,000 individual / $10,000 family non-participating providers. Deductible applies to all services, including prescription drug, before any copayment or coinsurance are applied.	Generally, you must pay all 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?	Professional services with copays or network preventive services.	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 deductibles for specific services?	Yes, $75/person for pediatric dental. There are no other specific deductibles.	You must pay all 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 participating providers $1,250 individual / $2,500 family; for non-participating providers $10,000 individual / $20,000 family.	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?	Pre-authorization penalties, 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 participating providers, see capbluecross.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		Limits, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-participating 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	$3 copayment/visit	50% coinsurance	None
	Specialist visit	$5 copayment/visit	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	Deductible does not apply to services at participating 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)	$20 copayment/service for Facility Owned Labs, $10 copayment/service for Independent Clinical Labs and no charge for tests.	50% coinsurance	Deductible waived at independent clinical labs. Deductible applies at hospital/facility owned labs.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	*See preauthorization schedule attached to your certificate of coverage.

*For more information about preauthorization, see the Preauthorization Program information attached to your certificate of coverage at www.capbluecross.com/sbcsia.

Common Medical Event	Services You May Need	What You Will Pay		Limits, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	
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	$2 copayment/prescription preferred and 10% coinsurance non-preferred (retail) $4 copayment/prescription preferred and 10% coinsurance non-preferred (mail)		Deductible waived for generic drugs. $100 max copayment(retail); $200 max copayment(mail order) for non preferred generic. No coverage for non-participating mail order prescriptions.
	Preferred brand drugs	$10 copayment/prescription (retail) $20 copayment/prescription (mail order)		No coverage for non-participating mail order prescriptions. Only select non-preferred brand drugs are covered.
	Non-preferred brand drugs	$25 copayment/prescription (retail) $50 copayment/prescription (mail order)		
	Specialty drugs	10% coinsurance preferred and 10% coinsurance non-preferred (generic) 10% coinsurance preferred and 10% coinsurance non-preferred (brand)		Prescription written for up to 30 days supply. / $200 maximum copayment/prescription preferred and $200 maximum copayment/prescription non-preferred (generic) / $200 maximum copayment/prescription preferred and $300 maximum copayment/prescription non-preferred (brand)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge Acute Care Hospital and $50 copayment Ambulatory Surgical Center	50% coinsurance	No coverage for services at non-participating ambulatory surgical facilities
	Physician/surgeon fees	No charge	50% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
If you need immediate medical attention	Emergency room care	$50 copayment/service	$50 copayment/service	Copayment waived if admitted inpatient.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$20 copayment/service	$20 copayment/service	Deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Physician/surgeon fees	No charge	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: $5 copayment/visit; all other outpatient services: No charge	50% coinsurance	None
	Inpatient services	No charge	50% coinsurance	None

*For more information about preauthorization, see the Preauthorization Program information attached to your certificate of coverage at www.capbluecross.com/sbcsia.

Common Medical Event	Services You May Need	What You Will Pay		Limits, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-participating Provider (You will pay the most)	
If you are pregnant	Office visits	$5 copayment/visit	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	No charge	50% coinsurance	
	Childbirth/delivery facility services	No charge	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	60 visit limit. *See preauthorization schedule attached to your certificate of coverage.
	Rehabilitation services	$5 copayment/visit	50% coinsurance	Visit Limit(per benefit period): Physical & occupational-30 combined; speech-30
	Habilitation services	$5 copayment/visit	50% coinsurance	Visit Limit(per benefit period): Physical & occupational-30 combined; speech-30 (visit limits not applicable to Mental Health care and Substance abuse services)
	Skilled nursing care	No charge	50% coinsurance	120 day limit.
	Durable medical equipment	No charge	50% coinsurance	*See preauthorization schedule attached to your certificate of coverage.
	Hospice services	No charge	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.	
	Children's dental check-up	No charge	20% coinsurance	Deductible does not apply

*For more information about preauthorization, see the Preauthorization Program information attached to your certificate of coverage at www.capbluecross.com/sbcsia.

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.)

- Abortions, except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed
- Bariatric surgery (unless medically necessary)
- 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 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: the Pennsylvania Insurance Department at 1-877-881-6388.

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 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.

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	$250
Specialist copayment	$5
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	**$ 12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$310

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

The plan's overall deductible	$250
Specialist copayment	$5
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	**$ 7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$810

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

The plan's overall deductible	$250
Specialist copayment	$5
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	**$ 1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$280

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

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Capital BlueCross
P.O. 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 interpete 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).
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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).
ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711)
Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).