Capital Blue Cross[1] Silver PPO 1500/5/5 CSR87 **Coverage For:** Individual and Family | **Plan Type:** PPO

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?	$1,500/Individual, $3,000/Family 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 $2,850/Individual, $5,700/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
		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	$5 copayment/Visit, Deductible does not apply	50% coinsurance	None
	Specialist visit	$10 copayment/Visit, Deductible does not apply	50% coinsurance	None
	Preventive care/screening/immunization	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)	$40 copayment for Facility Owned labs, $15 copayment, Deductible does not apply for Independent Labs and 5% coinsurance for tests. 5% coinsurance for outpatient radiology.	50% coinsurance	Copayment waived for mental health and substance use disorder lab services.
	Imaging (CT/PET scans, MRIs)	15% 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	$3 copayment/prescription, Deductible does not apply preferred and 15% coinsurance/prescription, Deductible does not apply non-preferred (retail) $8 copayment/prescription, Deductible does not apply preferred and 15% coinsurance/prescription, Deductible does not apply non-preferred (home delivery)		$150 maximum copayment(retail); $300 maximum copayment(home delivery) for non-preferred generic. Covers up to a 30-day supply (retail) 90-day supply (home delivery).
	Preferred brand drugs	$15 copayment/prescription (retail) $38 copayment/prescription (home delivery)		Covers up to a 30-day supply (retail) 90-day supply (home delivery).
	Non Preferred brand drugs	$40 copayment/prescription (retail) $100 copayment/prescription (home delivery)		Covers up to a 30-day supply (retail) 90-day supply (home delivery).
	Specialty drugs	30% 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
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
		30% coinsurance/prescription non-preferred (generic) 30% coinsurance/prescription preferred and 30% coinsurance/prescription non-preferred (brand)		supply. / $400 maximum copayment/prescription preferred and $400 maximum copayment/prescription non-preferred (generic) / $400 maximum copayment/prescription preferred and $500 maximum copayment/prescription non-preferred (brand)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance Acute Care Hospital and 5% coinsurance Ambulatory Surgical Center	50% coinsurance	No coverage for services at out-of-network ambulatory surgical facilities
	Physician/surgeon fees	5% coinsurance	50% coinsurance	*See preauthorization schedule attached to your plan document.
If you need immediate medical attention	Emergency room care	$75 copayment/Visit	$75 copayment/Visit	Copayment waived if admitted inpatient.
	Emergency medical transportation	5% coinsurance	5% coinsurance	Coinsurance waived for mental health and substance use disorder services.
	Urgent care	$35 copayment/Visit, Deductible does not apply	$35 copayment/Visit, Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	50% coinsurance	*See preauthorization schedule attached to your plan document.
	Physician/surgeon fees	5% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: $10 copayment/Visit, Deductible does not apply; all other outpatient services: 5% coinsurance	50% coinsurance	None
	Inpatient services	5% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	$10 copayment/Visit, Deductible does not apply	50% coinsurance	Depending on the type of services, a copayment, coinsurance or deductible may apply.
	Childbirth/delivery professional services	5% coinsurance	50% coinsurance	Depending on the type of services, a copayment, coinsurance or deductible may apply.

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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)	
	Childbirth/delivery facility services	5% 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	5% coinsurance	50% coinsurance	60 visits limit per benefit period. *See preauthorization schedule attached to your plan document.
	Rehabilitation services	$10 copayment/Visit, Deductible does not apply	50% coinsurance, Deductible does not apply	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	$10 copayment/Visit, Deductible does not apply	50% coinsurance, Deductible does not apply	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	5% coinsurance	50% coinsurance	120 day limit per benefit period
	Durable medical equipment	5% coinsurance	Not Covered	*See preauthorization schedule attached to your plan document.
	Hospice services	5% 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

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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	$1,500
Specialist copayment	$10
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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	$1,500
Copayments	$40
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,140**

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 copayment	$10
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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	$1,500
Copayments	$500
Coinsurance	$10
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$2,040**

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

The plan's overall deductible	$1,500
Specialist copayment	$10
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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	$1,500
Copayments	$70
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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CRC@capbluecross.com

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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).
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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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