



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>                                | \$1,800/Individual, \$3,600/Family <a href="#">preferred in-network providers</a> ;<br>\$4,000/Individual, \$8,000/Family <a href="#">non-preferred in-network providers</a> ;<br>\$5,000/Individual, \$10,000/Family <a href="#">out-of-network providers</a> .<br><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> | For <a href="#">in-network providers</a> \$8,550 Individual / \$17,100 Family;<br>for <a href="#">out-of-network providers</a> \$10,000 Individual / \$20,000/Family.<br>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                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                  |                                                         | Preferred In-network Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                                                                                                                                                 | Non-Preferred In-network Provider<br>(You will pay the least)                                                                                                                                                          | Out-of-network Provider<br>(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        | \$25 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply                                                                                                                                                                                                                                                                                                                                                                          | \$50 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply                                                                                                                                       | 50% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                  | <a href="#">Specialist</a> visit                        | \$50 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply                                                                                                                                                                                                                                                                                                                                                                          | \$75 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply                                                                                                                                       | 50% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                  | <a href="#">Preventive care/screening</a> /immunization | No Charge                                                                                                                                                                                                                                                                                                                                                                                                                                                 | No Charge                                                                                                                                                                                                              | 50% <a href="#">coinsurance</a>                    | <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 No Charge for tests. No Charge for outpatient radiology.                                                                                                                                                                                                                                                                                                                            | 30% <a href="#">coinsurance</a> for Facility Owned labs, 30% <a href="#">coinsurance</a> for Independent Labs and 30% <a href="#">coinsurance</a> for tests. 30% <a href="#">coinsurance</a> for outpatient radiology. | 50% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                  | Imaging (CT/PET scans, MRIs)                            | No Charge                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 30% <a href="#">coinsurance</a>                                                                                                                                                                                        | 50% <a href="#">coinsurance</a>                    | *See <a href="#">preauthorization</a> schedule attached to your plan document.                                                                                                                                                                                                              |
| If you need drugs to treat your illness or condition<br>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<br>\$20 <a href="#">copayment</a> /prescription, <a href="#">Deductible</a> does not apply non-preferred (retail)<br>\$25 <a href="#">copayment</a> /prescription, <a href="#">Deductible</a> does not apply preferred and<br>\$50 <a href="#">copayment</a> /prescription, <a href="#">Deductible</a> does not apply non-preferred (home delivery) |                                                                                                                                                                                                                        |                                                    | Covers up to a 30-day supply (retail) 90-day supply (home delivery).                                                                                                                                                                                                                        |
|                                                                                                                                                                  | Preferred brand drugs                                   | \$25 <a href="#">copayment</a> /prescription (retail)<br>\$63 <a href="#">copayment</a> /prescription (home delivery)                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                        |                                                    | Covers up to a 30-day supply (retail) 90-day supply (home delivery).                                                                                                                                                                                                                        |

| Common Medical Event                    | Services You May Need                            | What You Will Pay                                                                                                                                                                                                                                                          |                                                                                                                    |                                                                                  | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                         |                                                  | Preferred In-network Provider<br>(You will pay the least)                                                                                                                                                                                                                  | Non-Preferred In-network Provider<br>(You will pay the least)                                                      | Out-of-network Provider<br>(You will pay the most)                               |                                                                                                                                                                                                                                                                                                                                                          |
|                                         | Non Preferred brand drugs                        | \$75 <a href="#">copayment</a> /prescription (retail)<br>\$188 <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>                  | 40% <a href="#">coinsurance</a> /prescription preferred and<br>40% <a href="#">coinsurance</a> /prescription non-preferred (generic)<br>40% <a href="#">coinsurance</a> /prescription preferred and<br>40% <a href="#">coinsurance</a> /prescription non-preferred (brand) |                                                                                                                    |                                                                                  | Prescription written for up to 30 days supply. / \$800 maximum <a href="#">copayment</a> /prescription preferred and \$1,000 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)   | No Charge Acute Care Hospital and No Charge Ambulatory Surgical Center                                                                                                                                                                                                     | 30% <a href="#">coinsurance</a> Acute Care Hospital and 30% <a href="#">coinsurance</a> Ambulatory Surgical Center | 50% <a href="#">coinsurance</a>                                                  | No coverage for services at <a href="#">out-of-network</a> ambulatory surgical facilities                                                                                                                                                                                                                                                                |
|                                         | Physician/surgeon fees                           | No Charge                                                                                                                                                                                                                                                                  | 30% <a href="#">coinsurance</a>                                                                                    | 50% <a href="#">coinsurance</a>                                                  | *See <a href="#">preauthorization</a> schedule attached to your plan document.                                                                                                                                                                                                                                                                           |
| If you need immediate medical attention | <a href="#">Emergency room care</a>              | \$200 <a href="#">copayment</a> /Visit                                                                                                                                                                                                                                     | \$200 <a href="#">copayment</a> /Visit                                                                             | \$200 <a href="#">copayment</a> /Visit                                           | <a href="#">Copayment</a> waived if admitted inpatient.                                                                                                                                                                                                                                                                                                  |
|                                         | <a href="#">Emergency medical transportation</a> | No Charge                                                                                                                                                                                                                                                                  | No Charge                                                                                                          | No Charge                                                                        | None                                                                                                                                                                                                                                                                                                                                                     |
|                                         | <a href="#">Urgent care</a>                      | \$75 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply                                                                                                                                                                                           | \$75 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply                                   | \$75 <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)               | No Charge                                                                                                                                                                                                                                                                  | 30% <a href="#">coinsurance</a>                                                                                    | 50% <a href="#">coinsurance</a>                                                  | *See <a href="#">preauthorization</a> schedule attached to your plan document.                                                                                                                                                                                                                                                                           |
|                                         | Physician/surgeon fees                           | No Charge                                                                                                                                                                                                                                                                  | 30% <a href="#">coinsurance</a>                                                                                    | 50% <a href="#">coinsurance</a>                                                  | None                                                                                                                                                                                                                                                                                                                                                     |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                                                                                     |                                                                                                                                                       |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                      |
|---------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Preferred In-network Provider<br>(You will pay the least)                                                                                             | Non-Preferred In-network Provider<br>(You will pay the least)                                                                                         | Out-of-network Provider<br>(You will pay the most) |                                                                                                                                                                                                             |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Outpatient office visits: \$25 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply ; all other outpatient services: No Charge | Outpatient office visits: \$25 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply ; all other outpatient services: No Charge | 50% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                        |
|                                                                           | Inpatient services                        | No Charge                                                                                                                                             | No Charge                                                                                                                                             | 50% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                        |
| If you are pregnant                                                       | Office visits                             | \$50 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply                                                                      | \$75 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply                                                                      | 50% <a href="#">coinsurance</a>                    | 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                                                                                                                                             | 30% <a href="#">coinsurance</a>                                                                                                                       | 50% <a href="#">coinsurance</a>                    | 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                                                                                                                                             | 30% <a href="#">coinsurance</a>                                                                                                                       | 50% <a href="#">coinsurance</a>                    | 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                                                                                                                                             | 30% <a href="#">coinsurance</a>                                                                                                                       | 50% <a href="#">coinsurance</a>                    | 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>   | \$50 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply                                                                      | \$75 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply                                                                      | 50% <a href="#">coinsurance</a>                    |                                                                                                                                                                                                             |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                                                                            |                                                                                  |                                                                                              | Limitations, Exceptions, & Other Important Information                                                                                                                                                            |
|----------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                           | Preferred In-network Provider<br>(You will pay the least)                                                    | Non-Preferred In-network Provider<br>(You will pay the least)                    | Out-of-network Provider<br>(You will pay the most)                                           |                                                                                                                                                                                                                   |
|                                        |                                           |                                                                                                              |                                                                                  |                                                                                              | 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>     | \$50 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply                             | \$75 <a href="#">copayment</a> /Visit, <a href="#">Deductible</a> does not apply | 50% <a href="#">coinsurance</a>                                                              | 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>      | No Charge                                                                                                    | 30% <a href="#">coinsurance</a>                                                  | 50% <a href="#">coinsurance</a>                                                              | 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                                                                                                    | 30% <a href="#">coinsurance</a>                                                  | Not Covered                                                                                  | *See <a href="#">preauthorization</a> schedule attached to your plan document.                                                                                                                                    |
|                                        | <a href="#">Hospice services</a>          | No Charge                                                                                                    | 30% <a href="#">coinsurance</a>                                                  | 50% <a href="#">coinsurance</a>                                                              | 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 <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                                                                                                                                                                         |

### 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,800 |
| ■ <a href="#">Specialist copayment</a>                          | \$50    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">coinsurance</a>                             | 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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,800        |
| <a href="#">Copayments</a>        | \$60           |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$1,860</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,800 |
| ■ <a href="#">Specialist copayment</a>                          | \$50    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">coinsurance</a>                             | 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> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,800        |
| <a href="#">Copayments</a>        | \$800          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$2,600</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,800 |
| ■ <a href="#">Specialist copayment</a>                          | \$50    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 0%      |
| ■ Other <a href="#">coinsurance</a>                             | 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> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,800        |
| <a href="#">Copayments</a>        | \$400          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,200</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 Blue Shield Association. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.

## NOTICE OF AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES AND AUXILIARY AIDS AND SERVICES

We provide language assistance services and auxiliary aids free of charge by calling 800.962.2242 (TTY: 711).

Ofrecemos servicios de asistencia lingüística y ayuda auxiliar sin costo llamando al 800.962.2242 (TTY: 711).

请致电 800.962.2242 (TTY: 711)获取我们免费提供的语言协助服务和辅助工具。

我們免費提供語言協助服務與輔助工具，若有需要請致電 800.962.2242 (TTY:711)。

Мы бесплатно предоставляем услуги языковой поддержки и вспомогательные средства по телефону 800.962.2242 (TTY: 711).

Unter der Rufnummer 800.962.2242 (TTY: 711) stellen wir Ihnen kostenlose Sprachassistenzen und Hilfsmittel zur Verfügung.

Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ và các thiết bị hỗ trợ miễn phí thông qua số 800.962.2242 (TTY: 711).

نوفر خدمات المساعدة اللغوية والمساعدات الإضافية مجاًاً عن طريق الاتصال بالرقم 800.962.2242 (TTY: 711).

800.962.2242 (TTY: 711)번으로 전화하시면 무료로 언어 지원 서비스와 보조 지원 서비스를 제공해 드립니다.

Prestamos serviços linguísticos e de assistência auxiliar gratuitos ligando para o número 800.962.2242 (TTY: 711).

Nous fournissons des services d'assistance linguistique et des aides auxiliaires à titre gratuit au 800.962.2242 (TTY : 711).

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અમે 800.962.2242 (TTY: 711) પર કૉલ કરીને નિઃશુલ્ક ભાષા સહાય સેવાઓ અને સહાયક સહાય પ્રદાન કરીએ છીએ.

Zapewniamy bezpłatne usługi językowe i pomocnicze pod numerem telefonu 800.962.2242 (TTY: 711).

আমরা ভাষা সহায়তা পরিষেবা এবং সহায়ক উপকরণ বিনামূল্যে প্রদান করি। এর জন্য 800.962.2242 (TTY: 711) নম্বরে কল করুন।

भाषा सहायता सेवाएं और सहायक उपकरण निःशुल्क प्राप्त करने के लिए 800.962.2242 (TTY: 711) पर कॉल करें।