



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](http://www.cciio.cms.gov) or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$7,350 individual / \$14,700 family. <a href="#">Deductible</a> applies to all services, including <a href="#">prescription drug</a> , before any <a href="#">copayment</a> or <a href="#">coinsurance</a> are applied.	Generally, you must pay all 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 deductible?</b>	Yes. Professional services with copays or <a href="#">network preventive services</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <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 deductibles for specific services?</b>	Yes, \$75/person for pediatric dental. There are no other specific <a href="#">deductibles</a> .	You must pay all 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 services.
<b>What is the out-of-pocket limit for this plan?</b>	\$7,350 individual / \$14,700 family.	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 out-of-pocket limit?</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 network provider?</b>	Yes. For a list of participating <a href="#">providers</a> , see <a href="http://capbluecross.com">capbluecross.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 <a href="#">plan's 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 <a href="#">provider's</a> 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 referral to see a specialist?</b>	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

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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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$60 <a href="#">copayment</a> /visit	Not covered	None
	<a href="#">Specialist</a> visit	\$85 <a href="#">copayment</a> /visit	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	<a href="#">Deductible</a> does not apply to services at participating <a href="#">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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge x-ray; \$25 <a href="#">copayment</a> -independent clinical labs; No charge-hospital/facility owned labs.	Not covered	<a href="#">Deductible</a> waived at independent clinical labs. <a href="#">Deductible</a> applies at hospital/facility owned labs.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	*See <a href="#">preauthorization</a> schedule attached to your certificate of coverage.
<b>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</b>	Generic drugs	No charge(retail and mail order prescription)		Generic substitution applies, see <a href="#">plan</a> documents for details & info on the Advanced Choice <a href="#">network</a> . No coverage for non-participating mail order prescriptions.
	Preferred brand drugs	No charge(retail and mail order prescription)		
	Non-preferred brand drugs	No charge (select non-preferred) (retail and mail order prescription)		
	<a href="#">Specialty drugs</a>	50% <a href="#">coinsurance</a> per script (generic, preferred brand and select non-preferred brand drugs)	No coverage for specialty drug	Only select non-preferred drugs will be covered. Generic Substitution Program applies.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	*See <a href="#">preauthorization</a> 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](http://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 immediate medical attention	<a href="#">Emergency room care</a>	No charge	No charge	None
	<a href="#">Emergency medical transportation</a>	No charge	No charge	None
	<a href="#">Urgent care</a>	No charge	No charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	*See <a href="#">preauthorization</a> schedule attached to your certificate of coverage.
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$85 <a href="#">copayment</a> /individual session and \$85 <a href="#">copayment</a> /group session	Not covered	*See <a href="#">preauthorization</a> schedule attached to your certificate of coverage.
	Inpatient services	No charge	Not covered	None
If you are pregnant	Office visits	\$85 <a href="#">copayment</a> /visit	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	No Charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	Not covered	60 visit limit. *See <a href="#">preauthorization</a> schedule attached to your certificate of coverage.
	<a href="#">Rehabilitation services</a>	\$85 <a href="#">copayment</a> /visit	Not covered	Visit Limit(per benefit period): Physical & occupational-30 combined; speech-30
	<a href="#">Habilitation services</a>	\$85 <a href="#">copayment</a> /visit	Not covered	Visit Limit(per benefit period): Physical & occupational-30 combined; speech-30 (visit limits not applicable to Mental Health care and Substance abuse services)
	<a href="#">Skilled nursing care</a>	No charge	Not covered	120 day limit.
	<a href="#">Durable medical equipment</a>	No charge	Not covered	*See <a href="#">preauthorization</a> schedule attached to your certificate of coverage.
	<a href="#">Hospice services</a>	No charge	Not covered	None

\*For more information about preauthorization, see the Preauthorization Program information attached to your certificate of coverage at [www.capbluecross.com/SBCSIA](http://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)	
<b>If your child needs dental or eye care</b>	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.	
	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](#).)

- 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
- Acupuncture
- Bariatric surgery (unless medically necessary)
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Infertility treatment

**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-ebesa (3272) or [www.dol.gov/ebesa/healthreform](http://www.dol.gov/ebesa/healthreform) or the Pennsylvania Insurance Department at 1-877-881-6388 or [www.ra-in-consumer@state.pa.us](mailto:www.ra-in-consumer@state.pa.us). 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](http://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 or [www.ra-in-consumer@state.pa.us](http://www.ra-in-consumer@state.pa.us).

### 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](#).

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*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](#) \$7,350
- [Specialist copayment](#) \$85
- 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:**

<i>Cost Sharing</i>	
Deductibles	\$7,350
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,410</b>

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

- The [plan's](#) overall [deductible](#) \$7,350
- [Specialist copayment](#) \$85
- 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:**

<i>Cost Sharing</i>	
Deductibles	\$6,200
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$6,260</b>

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

- The [plan's](#) overall [deductible](#) \$7,350
- [Specialist copayment](#) \$85
- 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:**

<i>Cost Sharing</i>	
Deductibles	\$700
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$700</b>

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](mailto: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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Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).

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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 مجاناً إلى مترجم للغتك، يرجى الاتصال بـ 800.962.224  
(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 tłumaczem w języku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY: 711)

Pou pale avèk yon entèprèt nan lang ou gratis, rele nan 800.962.2242 (TTY: 711).

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Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).