



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at capbluecross.com or by calling 1-800-730-7219.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes, \$500/person/\$1,000/family for prescription drug. 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.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, \$6,350/person/ \$12,700/family; combined out-of-pocket limit for in-network medical and prescription drug.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u>?	Premium, balance-billed 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 .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. For a list of participating providers, see capbluecross.com or call 1-800-730-7219.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays for different kinds of providers .
Do I need a referral to see a <u>specialist</u>?	Yes. You need a written referral to see a specialist.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

IND_Generic-10-17-13-0335105-01-SBC_v7



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$50 copay/visit	Not covered	-----none-----
	Specialist visit	\$70 copay/visit	Not covered	-----none-----
	Other practitioner office visit	\$70 copay/visit for chiropractic	Not covered for chiropractic	Acupuncture not covered. Chiropractic not covered after 20 visits. Preauthorization is required for manipulation therapy. ²
	Preventive care / screening / immunization	No charge	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	\$200 copay/service x-ray; no charge lab at stand-alone labs; \$75 lab at hospital owned lab	Not covered	-----none-----
	Imaging (CT / PET scans, MRIs)	\$200 copay/service	Not covered	Preauthorization is required. ²

Questions: Call 1-800-730-7219 or visit us at capbluecross.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-730-7219 to request a copy.

² Preauthorization may apply. See your contract for a list of services requiring Preauthorization and penalties for failure to obtain Preauthorization.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at capbluecross.com	Generic drugs	\$20 copay (retail prescription) \$50 copay (mail order prescription)		Covers up to 30-day supply (retail prescription) 90-day supply (mail order prescription)
	Preferred brand drugs	\$65 copay (retail prescription) \$175 copay (mail order prescription)		
	Non-preferred brand drugs	\$110 copay (select non-preferred) (retail Rx) \$275 copay (select non-preferred) (mail order Rx)		Only select non-preferred drugs will be covered, all other non-preferred brand drugs are excluded.
	Specialty drugs	\$150 copay (generic) \$300 copay (preferred) \$450 copay (select non-preferred)		Only select non-preferred drugs will be covered, all other non-preferred brand drugs are excluded.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 copay/service	Not covered	-----none-----
	Physician / surgeon fees	No charge	Not covered	Preauthorization is required. ²
If you need immediate medical attention	Emergency room services	\$400 copay/service	\$400 copay/service	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	-----none-----
	Urgent care	\$100 copay/service	\$100 copay/service	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 copay/day	Not covered	Copay limited to 5 days/admission Preauthorization is required. ²
	Physician / surgeon fees	No charge	Not covered	-----none-----

Questions: Call 1-800-730-7219 or visit us at capbluecross.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ccio.cms.gov or call 1-800-730-7219 to request a copy.

² Preauthorization may apply. See your contract for a list of services requiring Preauthorization and penalties for failure to obtain Preauthorization.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$70 copay/individual session and \$70 copay/group session	Not covered	-----none-----
	Mental/Behavioral health inpatient services	No charge	Not covered	-----none-----
	Substance use disorder outpatient services	\$70 copay/partial session and \$70 copay/full session	Not covered	-----none-----
	Substance use disorder inpatient services	No charge	Not covered	-----none-----
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	-----none-----
	Delivery and all inpatient services	No charge	Not covered	-----none-----
If you need help recovering or have other special health needs	Home health care	\$50 copay/visit	Not covered	After 60 visits, not covered. Preauthorization is required. ²
	Rehabilitation services	\$70 copay/visit	Not covered	Visit Limit:Physical & occupational 60 combined;speech 60; (combined w/habilitative);respiratory 20.
	Habilitation services	\$70 copay/visit	Not covered	Visit Limit:Physical & occupational 60 combined; speech 60; (combined w/rehabilitative).
	Skilled nursing care	\$250 copay/day	Not covered	After 120 days, not covered. Copay limited to 5 days/admission.
	Durable medical equipment	\$400 copay/service	Not covered	Preauthorization required on items greater than or equal to \$500. ²
	Hospice service	\$250 copay/day	Not covered	Copay limited to 5 days.
If your child needs dental or eye care	Eye exam	No charge	Balance of retail charge after the following allowances: Exam \$32; Frames \$30; Lenses: Single \$24; Bifocal \$36; Trifocal \$46	Limited to one exam and one pair of glasses per year.
	Glasses	No charge for standard frames and lenses. See plan document for non-standard frame benefits.		
	Dental check-up	Not covered	Not covered	-----none-----

Questions: Call 1-800-730-7219 or visit us at capbluecross.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-730-7219 to request a copy.

² Preauthorization may apply. See your contract for a list of services requiring Preauthorization and penalties for failure to obtain Preauthorization.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Dental care (Adult) • Long-term care • Routine eye care (Adult)	• Bariatric surgery • Hearing aids • Non-emergency care when traveling outside the U.S. • Routine foot care	• Cosmetic surgery • Infertility • Private-duty nursing • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services & your costs for these services.)		
• Chiropractic care	Most coverage provided outside the United States. • See www.bcbs.com/shop-for-health-insurance/coverage-home-and-away.html	• Routine maternity

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium.

There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the state
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-730-7219. You may also contact your state insurance department at 1-877-881-6388 or ra-in-consumer@pa.gov

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Capital BlueCross at 1-800-962-2242. You may also contact the Pennsylvania Insurance Department at 1-877-881-6388 or www.insurance.pa.gov. If your group is subject to ERISA, you may contact the Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For additional assistance, you may contact the Pennsylvania consumer assistance line at 1-877-881-6388 or ra-in-comsumer@pa.gov.

Language Access Services:

Para obtener asistencia en Espanol, llame al 1-800-962-2242.

————— To see examples of how this plan might cover costs for a sample medical situation, see the next page. —————

Questions: Call **1-800-730-7219** or visit us at capbluecross.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call **1-800-730-7219** to request a copy.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for Important information about these examples.

Having a Baby (normal delivery)

■ Amount owed to providers:	\$7,540
■ Plan pays	\$6,520
■ Patient pays	\$1,020

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40

Total	\$7,540
--------------	----------------

Patient pays:

Deductibles	\$20
Copays	\$800
Coinsurance	\$0
Limits or exclusions	\$200

Total	\$1,020
--------------	----------------

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

■ Amount owed to providers:	\$5,400
■ Plan pays	\$2,620
■ Patient pays	\$2,780

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits & Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100

Total	\$5,400
--------------	----------------

Patient pays:

Deductibles	\$500
Copays	\$2,200
Coinsurance	\$0
Limits or exclusions	\$80

Total	\$2,780
--------------	----------------

Note: These numbers do NOT assume the patient is participating in our diabetes wellness program. If you have diabetes and participate in the wellness program, your costs may be lower. For more information about the diabetes wellness program, please contact us at 1-800-892-3033.

Questions: Call 1-800-730-7219 or visit us at capbluecross.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-730-7219 to request a copy.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

- 1** Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

Questions: Call **1-800-730-7219** or visit us at capbluecross.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call **1-800-730-7219** to request a copy.