



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, please contact the Bureau of Human Resources at 717-255-7306. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$250 individual / \$500 family in-network providers ; \$500 individual / \$1,000 family out-of-network providers .	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. In-network preventive services , emergency services or emergency medical transportation .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes, \$500 person/\$1,000 family (coinsurance) \$5,250/person/\$10,500/family (coinsurance/deductible/copayment) in-network providers ; \$1,000/person/\$2,000/family out-of-network providers .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums , balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. For a list of in-network providers , see capbluecross.com or call 1-800-962-2242.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limits, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copayment /visit	30% coinsurance	None
	Specialist visit	\$40 copayment /visit	30% coinsurance	None
	Preventive care/screening/immunization	No charge	30% coinsurance	Deductible does not apply to services at in-network providers . You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance for Facility Owned Labs, 10% coinsurance for Independent Clinical Labs and 10% coinsurance for tests. 10% coinsurance for outpatient radiology.	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	*See preauthorization schedule attached to your plan document.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.Benecardpbf.com or call 888-907-0070	Generic drugs	\$25	Not covered	For maintenance drugs, you can use the BeneCard Mail Order Program or any retail pharmacy. You can also go directly to BeneCard's facility in Mechanicsburg, PA. BeneCard's customer service toll-free number is 1-888-907-0070.
	Preferred brand drugs	\$50	Not covered	
	Non-preferred brand drugs	\$75	Not covered	
	Specialty drugs	Same as above (copays listed)		Must be filled by the BeneCard Mail Order Program. Limited to a 30 day supply.

*For more information about preauthorization, see the requirements document at <https://www.capbluecross.com/preauthorization>.

Common Medical Event	Services You May Need	What You Will Pay		Limits, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance Acute Care Hospital and 10% coinsurance Ambulatory Surgical Center	30% coinsurance	Services at out-of-network ambulatory surgical facilities 30% coinsurance .
	Physician/surgeon fees	10% coinsurance	30% coinsurance	*See preauthorization schedule attached to your plan document.
If you need immediate medical attention	Emergency room care	\$100 copayment /service	\$100 copayment /service	Deductible does not apply. Copayment waived if admitted inpatient.
	Emergency medical transportation	No charge	No charge	Deductible does not apply.
	Urgent care	\$40 copayment /service	30% coinsurance	Deductible does not apply for services at in-network providers .
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	*See preauthorization schedule attached to your plan document.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	None
If you are pregnant	Office visits	\$40 copayment /visit	30% coinsurance	Depending on the type of services, a copayment , coinsurance , or deductible may apply.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	90 visit limit per benefit period. *See preauthorization schedule attached to your plan document.
	Rehabilitation services	\$40 copayment /visit	30% coinsurance	Physical 20, speech 12 and occupational 12 visit limit.
	Habilitation services	\$40 copayment /visit	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	100 day limit per benefit period.
	Durable medical equipment	10% coinsurance	30% coinsurance	*See preauthorization schedule attached to your plan document.
	Hospice services	10% coinsurance	30% coinsurance	180 days.

*For more information about preauthorization, see the requirements document at <https://www.capbluecross.com/preauthorization>.

Common Medical Event	Services You May Need	What You Will Pay		Limits, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered		None

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](#).)

- | | | |
|--|-----------------------|--|
| • Acupuncture | • Glasses | • Preferred drugs |
| • Bariatric surgery (unless medically necessary) | • Hearing aids | • Routine eye care |
| • Cosmetic surgery | • Long-term care | • Routine foot care (unless medically necessary) |
| • Dental care | • Non-preferred drugs | • Weight loss programs |
| • Generic drugs | | |

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

- | | | |
|-------------------------|--|------------------------|
| • Chiropractic care | • Non-emergency care when traveling outside the U.S. | • Private-duty nursing |
| • 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-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit pennie.com or call 1-844-844-8040.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how 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: Capital Blue Cross at 1-800-962-2242 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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? No

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)**

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost | \$ 12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$1,520

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost | \$ 5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$200
Coinsurance	\$30
What isn't covered	
Limits or exclusions	\$4,100
The total Joe would pay is	\$4,580

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

Total Example Cost | \$ 2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$300
Coinsurance	\$70
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$630

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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Capital Blue Cross

PO Box 779880, Harrisburg, PA 17177-9880

800.417.7842 (TTY: 711), fax: 855.990.9001

CRC@capbluecross.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW., Room 509F, HHH Building, Washington, D.C. 20201, Toll-free 800.368.1019, 800.537.7697 (TDD). Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

Language assistance

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).

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Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).

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

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Per parlare con un interprete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711)

للتحدث مجاناً إلى مترجم للغتك، برجر، الاتصال بـ 800.962.2242 (الهاتف النصي: 711)

Pour parler à un interprète 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 grastis, rele nan 800.962.2242 (TTY: 711).

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