



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, call 1-866-787-9872. 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 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
<a href="#">What is the overall deductible?</a>	\$0 individual <a href="#">in-network providers</a> ; \$500 individual / \$1,000 family <a href="#">out-of-network providers</a> .	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> .
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. <a href="#">Emergency services</a> or <a href="#">emergency medical transportation</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> .
<a href="#">Are there deductibles for specific services?</a>	Yes. \$50 annual calendar year deductible per person for prescription drugs purchased at Retail Pharmacy.	You must pay all of the costs for these services up to a specific <a href="#">deductible</a> amount before this plan begins to pay for these services.
<a href="#">What is the out-of-pocket limit for this plan?</a>	Medical: for <a href="#">in-network providers</a> \$5,300 individual / \$10,600 family; Prescription Drug: for in-network providers \$5,300 individual / \$10,600 family; for <a href="#">out-of-network providers</a> \$3,000 individual / \$6,000 family (coinsurance OOPM).	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.
<a href="#">What is not included in the out-of-pocket limit?</a>	Pre-authorization penalties, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover. Certain specialty pharmacy drugs are considered non-essential health benefits under ACA and fall outside the <a href="#">out-of-pocket limits</a> .	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> . The cost of these certain specialty pharmacy drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your <a href="#">out-of-pocket limit</a> .
<a href="#">Will you pay less if you use a network provider?</a>	Yes. For a list of <a href="#">in-network providers</a> , see <a href="http://capbluecross.com">capbluecross.com</a> or call 1-800-962-2242.	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.
<a href="#">Do you need a referral to see a specialist?</a>	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		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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copayment</a> /visit	30% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$20 <a href="#">copayment</a> /visit	30% <a href="#">coinsurance</a>	None
	Preventive care/screening/immunization	No charge	30% <a href="#">coinsurance</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	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	No charge	30% <a href="#">coinsurance</a>	*See <a href="#">preauthorization</a> schedule attached to your <a href="#">plan</a> document.
If you need drugs to treat your illness or condition. More information about <a href="#">prescription drug coverage</a> is available by calling Express Scripts	Generic drugs	20% copay to a \$25 maximum payment for a Retail prescription. 15% copay to a \$15 maximum payment for a Mail Order prescription.	20% copay to a \$25 maximum payment for a Retail prescription. 15% copay to a \$15 maximum payment for a Mail Order prescription.	Covers up to a 31-day supply for Retail and 90-day supply for Mail Order. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Brand name drugs with no generic equivalents	25% copay to a \$50 maximum payment for a Retail prescription. 25% copay to a \$50 maximum payment for a Mail Order prescription.	25% copay to a \$50 maximum payment for a Retail prescription. 25% copay to a \$50 maximum payment for a Mail Order prescription.	Covers up to a 31-day supply for Retail and 90-day supply for Mail Order. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Multi-Source brand name drugs with generic equivalents	30% copay to a \$50 maximum payment for a Retail prescription. 30% copay to a \$50 maximum payment for a Mail Order prescription.	30% copay to a \$50 maximum payment for a Retail prescription. 30% copay to a \$50 maximum payment for a Mail Order prescription.	Covers up to a 31-day supply for Retail and 90-day supply for Mail Order. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	<a href="#">Specialty drugs</a>	Applicable base copays	Applicable base copays	Cost varies based on tier and coverage status. See above for cost details of covered drugs. Limitations and Exceptions may apply. Visit <a href="http://www.express-scripts.com">www.express-scripts.com</a> or call member services.
	Facility fee (e.g., ambulatory surgery center)	No charge	50% <a href="#">coinsurance</a>	Services at <a href="#">out-of-network</a> ambulatory surgical facilities 50% <a href="#">coinsurance</a> .
If you have outpatient surgery	Physician/surgeon fees	No charge	30% <a href="#">coinsurance</a>	*See <a href="#">preauthorization</a> schedule attached to your <a href="#">plan</a> document.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$100 <a href="#">copayment</a> /service	\$100 <a href="#">copayment</a> /service	<a href="#">Deductible</a> does not apply. <a href="#">Copayment</a> waived if admitted inpatient.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	<a href="#">Deductible</a> does not apply.
	<a href="#">Urgent care</a>	\$50 <a href="#">copayment</a> /service	30% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply for services at <a href="#">in-network providers</a> .

\*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 a hospital stay	Facility fee (e.g., hospital room)	No charge	50% <a href="#">coinsurance</a>	*See <a href="#">preauthorization</a> schedule attached to your <a href="#">plan</a> document.
	Physician/surgeon fees	No charge	30% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <a href="#">copayment</a> /visit	30% <a href="#">coinsurance</a>	None
	Inpatient services	No charge	30% <a href="#">coinsurance</a>	None
If you are pregnant	Office visits	\$20 <a href="#">copayment</a> /visit	30% <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>	
	Childbirth/delivery facility services	No charge	50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	50% <a href="#">coinsurance</a>	90 visit limit per benefit period. *See <a href="#">preauthorization</a> schedule attached to your <a href="#">plan</a> document.
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copayment</a> /visit	30% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Habilitation services</a>	\$20 <a href="#">copayment</a> /visit	30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	No charge	50% <a href="#">coinsurance</a>	100 day limit per benefit period.
	<a href="#">Durable medical equipment</a>	No charge	30% <a href="#">coinsurance</a>	*See <a href="#">preauthorization</a> schedule attached to your <a href="#">plan</a> document.
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	Not covered	None

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

## 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	• Routine eye care
• Bariatric surgery (unless medically necessary)	• Hearing aids	• Routine foot care (unless medically necessary)
• Cosmetic surgery	• Long-term care	• Weight loss programs
• Dental care		

### 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](http://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](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 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 1-866-787-9872 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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? **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](#).

*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>	\$0
<a href="#">Specialist copayment</a>	\$20
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*)

**Total Example Cost** \$ 12,700

#### In this example, Peg would pay:

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

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

### 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>	\$0
<a href="#">Specialist copayment</a>	\$20
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*)

**Total Example Cost** \$ 5,600

#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$4,100
The total Joe would pay is	
	\$4,200

### Mia's Simple Fracture

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

The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
<a href="#">Specialist copayment</a>	\$20
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*)

**Total Example Cost** \$ 2,800

#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	
	\$210

## 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 Sprachassistenzdienste 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 مجاناً 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).

Nou bay sèvis asistans pou lang ak èd siplémentè gratis; pou jwenn èd rele nan 800.962.2242 (TTY: 711).

Forniamo gratuitamente servizi di assistenza linguistica e supporti ausiliari chiamando il numero 800.962.2242 (TTY: 711).

અમે 800.962.2242 (TTY: 711) પર કોલ 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।