



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:
<b>What is the overall <a href="#">deductible</a>?</b>	\$500 individual / \$1,500 family <a href="#">in-network providers</a> ; \$500 individual / \$1,500 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Professional services with copays, <a href="#">in-network preventive services</a> , <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> .
<b>Are there <a href="#">deductibles</a> for specific services?</b>	Yes. \$50 annual calendar year <a href="#">deductible</a> per person for prescription drugs purchased at Retail pharmacy. Limited to \$150 per family.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this plan begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$500/person/\$1,500/family <a href="#">in-network providers</a> ( <a href="#">coinsurance</a> ); Medical: \$3,000/person/\$6,000/family <a href="#">out-of-network providers</a> ( <a href="#">coinsurance</a> ); Medical: \$4,600/person/\$9,200/family ( <a href="#">coinsurance</a> / <a href="#">copayment</a> / <a href="#">deductible</a> ) <a href="#">in-network providers</a> ; Prescription Drug: \$4,600/person/\$9,200 family <a href="#">in-network providers</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>	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> .
<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://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.
<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		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 office or clinic</a>	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	\$40 <a href="#">copayment</a> /visit	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	30% <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)	10% <a href="#">coinsurance</a> for Facility Owned Labs, 10% <a href="#">coinsurance</a> for Independent Clinical Labs and 10% <a href="#">coinsurance</a> for tests. 10% <a href="#">coinsurance</a> for outpatient radiology.	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	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	Up to \$10 copay for Retail Up to \$20 copay for Mail Order	Up to \$10 copay for Retail Up to \$20 copay for Mail Order	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. You pay the difference in cost if you request a brand instead of its generic equivalent. After the prescription is filled three times at Retail, 100% Retail coinsurance applies with no out-of-pocket maximum. Your plan uses a preferred drug list.
	Preferred brand drugs	Up to \$35 copay for Retail Up to \$70 copay for Mail Order	Up to \$35 copay for Retail Up to \$70 copay for Mail Order	
	Non-preferred brand drugs	Up to \$75 copay for Retail Up to \$150 copay for Mail Order	Up to \$75 copay for Retail Up to \$150 copay for Mail Order	
	<a href="#">Specialty drugs</a>	Applicable base copays	Applicable base copays	Cost varies based on tier and coverage status. See above for details. Limitations and Exceptions may apply. Visit <a href="http://www.express-scripts.com">www.express-scripts.com</a> or call member services.

\*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% <a href="#">coinsurance</a> Acute Care Hospital and 10% <a href="#">coinsurance</a> Ambulatory Surgical Center	50% <a href="#">coinsurance</a>	Services at <a href="#">out-of-network</a> ambulatory surgical facilities 50% <a href="#">coinsurance</a> .
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	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> .
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	*See <a href="#">preauthorization</a> schedule attached to your <a href="#">plan</a> document.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <a href="#">copayment</a> /visit	30% <a href="#">coinsurance</a>	None
	Inpatient services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
If you are pregnant	Office visits	\$40 <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	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	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>	\$40 <a href="#">copayment</a> /visit	30% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Habilitation services</a>	\$40 <a href="#">copayment</a> /visit	30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	100 day limit per benefit period.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	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	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	None
	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](#).

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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](#) \$500
- [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:**

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$1,770</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [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:**

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,100
<b>The total Joe would pay is</b>	<b>\$4,800</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [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:**

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$300
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$850</b>

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).

欲免费用本国语言咨询传译员 · 请拨电话 800.962.2242 (TTY: 711).

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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무료 전화 통역 서비스 800.962.2242 (TTY: 711).

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

للتحدث مجاناً إلى مترجم للغتك، برج، الاتصال بـ 800.962.2242 (الهاتف النصم: 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).

දුරකථන මගින් වැරදි නොවන ආකාරයට, 800.962.2242 (TTY: 711) ට කථා කරන්න.

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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