⚠️ 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 or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,700 individual / $3,400 family. Deductible applies to all services, including prescription drug, before any copayment or coinsurance are applied.	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive services.	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?	For in-network providers $8,500 individual / $17,000 family; for out-of-network providers $5,000 individual / $10,000 family, combined out-of-pocket limit for medical and prescription drug.	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?	Pre-authorization penalties, premiums, balance billing charges, and health care this plan doesn't cover. Certain specialty pharmacy drugs are considered non-essential health benefits under the ACA and fall outside the out-of-pocket limits.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. 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 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.

00521834-2-13-23-1615648-01-SBC_v22-PPQSK252/None

⚠️	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	20% coinsurance	None
	Specialist visit	$40 copayment/visit	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	20% 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)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% 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 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. You are responsbile for full cost up to your annual deductible. Some drugs may require pre-authorization. If the necessary pre-authorization 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 a prescription is filled three times at Retail. a 100% 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	
	Specialty drugs	Applicable base copays	Applicable base copays	Cost varies based on tier and coverage status. See above for details. Limitations and Exceptions may apply. Visit www.express-scripts.com or call member
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% coinsurance	Services at out-of-network ambulatory surgical facilities 50% coinsurance.
	Physician/surgeon fees	No charge	20% coinsurance	*See preauthorization schedule attached to your plan document.
If you need immediate medical attention	Emergency room care	$100 copayment/service	$100 copayment/service	Copayment waived if admitted inpatient.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$50 copayment/service	20% coinsurance	None

*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% coinsurance	*See preauthorization schedule attached to your plan document.
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copayment/visit	20% coinsurance	None
	Inpatient services	No charge	20% coinsurance	None
If you are pregnant	Office visits	$40 copayment/visit	20% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	90 visit limit per benefit period. *See preauthorization schedule attached to your plan document.
	Rehabilitation services	$40 copayment/visit	20% coinsurance	Physical 20, speech 12 and occupational 20 visit limit.
	Habilitation services	$40 copayment/visit	20% coinsurance	
	Skilled nursing care	No charge	50% coinsurance	100 day limit per benefit period.
	Durable medical equipment	No charge	20% coinsurance	*See preauthorization schedule attached to your plan document.
	Hospice services	No charge	20% coinsurance	None
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

*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		
• Bariatric surgery (unless medically necessary)	• Glasses	• Routine eye care
• Cosmetic surgery	• Hearing aids	• Routine foot care (unless medically necessary)
• Dental care	• Long-term 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	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing

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

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)	**Managing Joe's type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)	**Mia's Simple Fracture** (in-network emergency room visit and follow up care)
■ The plan's overall deductible $1,700	■ The plan's overall deductible $1,700	■ The plan's overall deductible $1,700
■ Specialist copayment $40	■ Specialist copayment $40	■ Specialist copayment $40
■ Hospital (facility) coinsurance 0%	■ Hospital (facility) coinsurance 0%	■ Hospital (facility) coinsurance 0%
■ Other coinsurance 0%	■ Other coinsurance 0%	■ Other coinsurance 0%

This EXAMPLE event includes services like:

Peg	Joe	Mia
Specialist office visits (prenatal care)	Primary care physician office visits (including disease education)	Emergency room care (including medical supplies)
Childbirth/Delivery Professional Services	Diagnostic tests (blood work)	Diagnostic test (x-ray)
Childbirth/Delivery Facility Services	Prescription drugs	Durable medical equipment (crutches)
Diagnostic tests (ultrasounds and blood work)	Durable medical equipment (glucose meter)	Rehabilitation services (physical therapy)
Specialist visit (anesthesia)		

Total Example Cost	**$ 12,700**	**Total Example Cost**	**$ 5,600**	**Total Example Cost**	**$ 2,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$1,770**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,100
The total Joe would pay is	**$5,400**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,910**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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 مجانًا 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 siplemantè 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 કૉલ 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।