



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 ? | \$2,000 individual / \$4,000 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 . |



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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$20 <u>copayment</u> /visit | 20% <u>coinsurance</u> | None | |
| | <u>Specialist</u> visit | \$40 <u>copayment</u> /visit | 20% <u>coinsurance</u> | None | |
| | <u>Preventive care/screening/immunization</u> | No charge | 20% <u>coinsurance</u> | <u>Deductible</u> does not apply to services at <u>in-network providers</u> . You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for. | |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No charge | 20% <u>coinsurance</u> | None | |
| | Imaging (CT/PET scans, MRIs) | No charge | 20% <u>coinsurance</u> | *See <u>preauthorization</u> schedule attached to your <u>plan</u> document. | |
| If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> 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 to \$20 copay for Mail Order | Up | Covers up to a 31-day supply for Retail and 90-day supply for Mail Order. You are responsible 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 to \$150 copay for Mail Order | Up | |
| | <u>Specialty drugs</u> | 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 services. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 50% <u>coinsurance</u> | Services at <u>out-of-network</u> ambulatory surgical facilities 50% <u>coinsurance</u> . | |
| | Physician/surgeon fees | No charge | 20% <u>coinsurance</u> | *See <u>preauthorization</u> schedule attached to your <u>plan</u> document. | |
| If you need immediate medical attention | <u>Emergency room care</u> | \$100 <u>copayment</u> /service | \$100 <u>copayment</u> /service | <u>Copayment</u> waived if admitted inpatient. | |
| | <u>Emergency medical transportation</u> | No charge | No charge | None | |
| | <u>Urgent care</u> | \$50 <u>copayment</u> /service | 20% <u>coinsurance</u> | 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 | 100 day limit per benefit period. |
| | Skilled nursing care | No charge | 50% coinsurance | *See preauthorization schedule attached to your plan document. |
| | Durable medical equipment | No charge | 20% coinsurance | |
| If your child needs dental or eye care | Hospice services | No charge | 20% coinsurance | 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. 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)

| | |
|---|---------|
| ■ The plan's overall deductible | \$2,000 |
| ■ Specialist copayment | \$40 |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 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 | \$2,000 |
| Copayments | \$0 |
| Coinsurance | \$0 |

What isn't covered

| | |
|-----------------------------------|----------------|
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$2,070 |

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$2,000 |
| ■ Specialist copayment | \$40 |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 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 | \$1,300 |
| Copayments | \$0 |
| Coinsurance | \$0 |

What isn't covered

| | |
|-----------------------------------|----------------|
| Limits or exclusions | \$4,100 |
| The total Joe would pay is | \$5,400 |

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$2,000 |
| ■ Specialist copayment | \$40 |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 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 | \$2,000 |
| Copayments | \$200 |
| Coinsurance | \$0 |

What isn't covered

| | |
|-----------------------------------|----------------|
| Limits or exclusions | \$10 |
| The total Mia would pay is | \$2,210 |

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

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



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।