



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?	\$1,400 individual / \$2,800 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 \$7,050 individual / \$14,100 family; for out-of-network providers \$5,000 individual / \$10,000 family combined out-of-pocket limit for medical and prescription drug . (coinsurance)	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 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 1-866-787-9872	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 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 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 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)	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
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	50% 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 | • 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 BlueCross 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](#) \$1,400
- [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	\$1,400
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$1,470

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

- The [plan's](#) overall [deductible](#) \$1,400
- [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](#) \$1,400
- [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	\$1,400
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$1,610

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

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Capital BlueCross

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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).

欲免費用本國語言洽詢傳譯員 · 請撥電話 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 مجانًا إلى مترجم للغتك، يرجى 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).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711)

Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).