



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 1-800-962-2242. 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>                                | \$6,000 individual / \$6,000 family <a href="#">in-network providers</a> ; \$10,000 individual / \$10,000 family <a href="#">out-of-network providers</a> per <a href="#">plan</a> year. <a href="#">Deductible</a> applies to all services, including <a href="#">prescription drug</a> , before any <a href="#">copayment</a> or <a href="#">coinsurance</a> are applied. | 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> , the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.   |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. <a href="#">In-network preventive services</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>                   | No.   | You don't have to meet <a href="#">deductibles</a> for specific services.  |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | For <a href="#">in-network providers</a> \$7,000 individual / \$7,000 family; for <a href="#">out-of-network providers</a> \$20,000 individual / \$20,000 family combined <a href="#">out-of-pocket limit</a> for medical and <a href="#">prescription drug</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>               | <a href="#">Premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.  | Even though you pay these expenses, they don't count toward the <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<br>(You will pay the least)  | Out-of-network Provider<br>(You will pay the most) |   |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>   | Primary care visit to treat an injury or illness       | \$20 <a href="#">copayment</a> /visit  | 50% <a href="#">coinsurance</a>                    | None  |
|   | <a href="#">Specialist</a> visit                       | \$30 <a href="#">copayment</a> /visit  | 50% <a href="#">coinsurance</a>                    | None  |
|   | <a href="#">Preventive care/screening/immunization</a> | No charge  | 50% <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. |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | No charge  | 50% <a href="#">coinsurance</a>                    | None  |
|   | Imaging (CT/PET scans, MRIs)                           | No charge  | 50% <a href="#">coinsurance</a>                    | *See <a href="#">preauthorization</a> schedule attached to your <a href="#">plan</a> document.  |
| <b>If you need drugs to treat your illness or condition. More information about <a href="#">prescription drug coverage</a> is available by calling 1-800-962-2242</b> | Generic drugs  | \$5 <a href="#">copayment</a> /prescription preferred and \$5 <a href="#">copayment</a> /prescription non-preferred (retail) \$10 <a href="#">copayment</a> /prescription preferred and \$10 <a href="#">copayment</a> /prescription non-preferred (home delivery) |  | Covers up to 30-day supply (retail) 90-day supply (home delivery)   |
|   | Preferred brand drugs                                  | \$35 <a href="#">copayment</a> /prescription (retail) \$70 <a href="#">copayment</a> /prescription (home delivery)   |  |   |
|   | Non-preferred brand drugs                              | \$70 <a href="#">copayment</a> /prescription (retail) \$140 <a href="#">copayment</a> /prescription (home delivery)  |  |   |
|   | <a href="#">Specialty drugs</a>                        | \$100 <a href="#">copayment</a> /prescription preferred and \$100 <a href="#">copayment</a> /prescription non-preferred (generic) \$100 <a href="#">copayment</a> /prescription preferred and \$100 <a href="#">copayment</a> /prescription non-preferred (brand)  |  | Prescription written for up to 30 days supply. (generic) (brand)  |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)         | No charge  | 50% <a href="#">coinsurance</a>                    | No coverage for services at <a href="#">out-of-network</a> ambulatory surgical facilities   |
|   | Physician/surgeon fees                                 | No charge  | 50% <a href="#">coinsurance</a>                    | *See <a href="#">preauthorization</a> schedule attached to your <a href="#">plan</a> document.  |

\*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<br>(You will pay the least)  | Out-of-network Provider<br>(You will pay the most)   |   |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$500 <a href="#">copayment</a> , waived if admitted, then subject to <a href="#">deductible</a> | \$500 <a href="#">copayment</a> , waived if admitted, then subject to <a href="#">deductible</a> | <a href="#">Copayment</a> waived if admitted inpatient.   |
|   | <a href="#">Emergency medical transportation</a> | No charge  | No charge  | None  |
|   | <a href="#">Urgent care</a>                      | \$50 <a href="#">copayment</a> /service  | 50% <a href="#">coinsurance</a>  | None  |
| 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  | 50% <a href="#">coinsurance</a>  | None  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$30 <a href="#">copayment</a> /visit  | 50% <a href="#">coinsurance</a>  | None  |
|   | Inpatient services                               | No charge  | 50% <a href="#">coinsurance</a>  | None  |
| If you are pregnant   | Office visits                                    | \$30 <a href="#">copayment</a> /visit  | 50% <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  | 50% <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>          | \$30 <a href="#">copayment</a> /visit  | 50% <a href="#">coinsurance</a>  | 30 visits per therapy, combined with Habilitation   |
|   | <a href="#">Habilitation services</a>            | \$30 <a href="#">copayment</a> /visit  | 50% <a href="#">coinsurance</a>  | 30 visits per therapy, combined with Rehabilitation   |
|   | <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  | 50% <a href="#">coinsurance</a>  | *See <a href="#">preauthorization</a> schedule attached to your <a href="#">plan</a> document.  |
|   | <a href="#">Hospice services</a>                 | No charge  | 50% <a href="#">coinsurance</a>  | 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                                    | • Private-duty nursing |  |

### 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. |
|---------------------|-------------------------|--|

**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 1-800-962-2242 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](#) \$6,000
- [Specialist copayment](#) \$30
- 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:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$6,000        |
| Copayments                        | \$10           |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$6,070</b> |

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

- The [plan's](#) overall [deductible](#) \$6,000
- [Specialist copayment](#) \$30
- 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:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$5,300        |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$5,320</b> |

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

- The [plan's](#) overall [deductible](#) \$6,000
- [Specialist copayment](#) \$30
- 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:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,400        |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,400</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).

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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).

Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).

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، برجر، 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).

දැඩැචියා ඉදි වැළ කැවැ, 800.962.2242 (TTY: 711) ට කැවැ කැවැ.

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).

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