



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 1-855-300-2273. 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 in-network providers ; \$2,800 individual / \$5,600 family out-of-network providers .	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 , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
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?	Yes. \$50 individual / \$150 family for prescription drug . Applies to retail and specialty. There are no other specific deductibles .	You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers \$5,500 individual / \$12,000 family; for out-of-network providers \$9,900 individual / \$24,000 family combined out-of-pocket limit for network 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?	Premiums , balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the 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	25% coinsurance	50% coinsurance	None
	Specialist visit	25% coinsurance	50% coinsurance	None
	Preventive care/screening/immunization	No charge	50% 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)	40% coinsurance for facility labs, 15% coinsurance for independent labs and 25% coinsurance for tests. 25% coinsurance for outpatient radiology.	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	*See preauthorization schedule attached to your plan 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 (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available by calling 1-855-300-2273	Generic drugs	20% coinsurance preferred and 20% coinsurance non-preferred (retail)		Covers up to 30-day supply / \$5 minimum copayment /prescription preferred and \$5 minimum copayment /prescription non-preferred (retail) No coverage for home delivery
	Preferred brand drugs	20% coinsurance (retail)		Covers up to 30-day supply \$10 minimum copayment /prescription (retail) No coverage for home delivery
	Non-preferred brand drugs	30% coinsurance (retail)		Covers up to 30-day supply \$25 minimum copayment /prescription (retail) No coverage for home delivery
	Specialty drugs	20% coinsurance preferred and 20% coinsurance non-preferred (generic) 20% coinsurance preferred and 30% coinsurance non-preferred (brand)		Prescription written for up to 30 days supply. / \$5 minimum copayment /prescription preferred and \$5 minimum copayment /prescription non-preferred (generic) / \$10 minimum copayment /prescription preferred and \$25 minimum copayment /prescription non-preferred (brand)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance Acute Care Hospital and 15% coinsurance Ambulatory Surgical Center	50% coinsurance	No coverage for services at out-of-network ambulatory surgical facilities
	Physician/surgeon fees	25% coinsurance	50% coinsurance	*See preauthorization schedule attached to your plan document.
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	None
	Emergency medical transportation	25% coinsurance	25% coinsurance	None
	Urgent care	25% coinsurance	25% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	*See preauthorization schedule attached to your plan document.
	Physician/surgeon fees	25% coinsurance	50% 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 need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	50% coinsurance	None
	Inpatient services	25% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	25% coinsurance	50% coinsurance	Depending on the type of services, a copayment , coinsurance , or deductible may apply.
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	*See preauthorization schedule attached to your plan document.
	Rehabilitation services	25% coinsurance	50% coinsurance	30 visit limit per benefit period
	Habilitation services	25% coinsurance	50% coinsurance	
	Skilled nursing care	25% coinsurance	50% coinsurance	100 day limit per benefit period.
	Durable medical equipment	25% coinsurance	50% coinsurance	*See preauthorization schedule attached to your plan document.
	Hospice services	25% coinsurance	50% 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) | • Long-term care | • Routine foot care (unless medically necessary) |
| • Cosmetic surgery | • Private-duty nursing | • 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 | • Infertility treatment | • Non-emergency care when traveling outside the U.S. |
| • Hearing aids | | |

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 1-855-300-2273 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](#) \$1,700
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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	\$1,700
Copayments	\$0
Coinsurance	\$2,600
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,360

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

- The [plan's](#) overall [deductible](#) \$1,700
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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	\$600
Copayments	\$0
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,620

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

- The [plan's](#) overall [deductible](#) \$1,700
- [Specialist copayment](#) \$0
- Hospital (facility) [coinsurance](#) 25%
- Other [coinsurance](#) 25%

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	\$900
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$900

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 Sprachassistentendienste 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 કોલ કરીને નિ:શુલ્ક 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 नि:शुल्क प्राप्त करने के लिए 800.962.2242 (TTY: 711) पर कॉल करें।

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