



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](http://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 <a href="#">deductible</a> ?	Not applicable	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">In-network preventive services</a> , <a href="#">emergency services</a> or <a href="#">emergency medical transportation</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.
Are there <a href="#">deductibles</a> for specific services?	Yes. <b>\$100</b> individual / <b>\$300</b> family for major medical services. Yes. <a href="#">In-network preventive services</a> , <a href="#">emergency services</a> or <a href="#">emergency medical transportation</a> . There are no other specific <a href="#">deductibles</a> .	You must pay all the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Not applicable.	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not Applicable.	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
Will you pay less if you use a <a href="#">network provider</a> ?	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.	You pay the least if you use a <a href="#">provider</a> in the hospital/professional <a href="#">in-network providers</a> tier. You pay more if you use a <a href="#">provider</a> in the major medical tier. 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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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
		Hospital/ Professional (In-Network Provider) (You will pay the least)	Major Medical	Hospital/ Professional (Out-of-Network Provider) (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Not covered	20% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Specialist</a> visit	Not covered	20% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	20% <a href="#">coinsurance</a>	No charge	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	20% <a href="#">coinsurance</a>	No charge	None
	Imaging (CT/PET scans, MRIs)	No charge	20% <a href="#">coinsurance</a>	No charge	None
If you need drugs to treat your illness or condition. More information about <a href="#">prescription drug coverage</a> is available by calling 1-866-787-9872	Generic drugs	Not covered			None
	Preferred brand drugs	Not covered			None
	Non-preferred brand drugs	Not covered			None
	<a href="#">Specialty drugs</a>	No coverage for <a href="#">specialty drug</a>			None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	No coverage for services at <a href="#">out-of-network</a> ambulatory surgical facilities
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	No charge	*See <a href="#">preauthorization</a> schedule attached to your <a href="#">plan</a> document.
If you need immediate medical attention	<a href="#">Emergency room care</a>	No charge	No charge	No charge	<a href="#">Deductible</a> does not apply.
	<a href="#">Emergency medical transportation</a>	Not covered	No charge	Not covered	<a href="#">Deductible</a> does not apply.
	<a href="#">Urgent care</a>	No charge	No charge	No charge	

\*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
		Hospital/ Professional (In-Network Provider) (You will pay the least)	Major Medical	Hospital/ Professional (Out-of-Network Provider) (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	*See <a href="#">preauthorization</a> schedule attached to your <a href="#">plan</a> document.
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	No charge	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	20% <a href="#">coinsurance</a>	Not covered	None
	Inpatient services	No charge	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	None
If you are pregnant	Office visits	Not covered	20% <a href="#">coinsurance</a>	Not covered	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	20% <a href="#">coinsurance</a>	No charge	
	Childbirth/delivery facility services	No charge	20% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	20% <a href="#">coinsurance</a>	Not covered	30 visit limit per benefit period. *See <a href="#">preauthorization</a> schedule attached to your <a href="#">plan</a> document.
	<a href="#">Rehabilitation services</a>	Not covered	20% <a href="#">coinsurance</a>	Not covered	-----none-----
	<a href="#">Habilitation services</a>	Not covered	20% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Skilled nursing care</a>	Not covered	20% <a href="#">coinsurance</a>	Not covered	100 day limit per benefit period.
	<a href="#">Durable medical equipment</a>	Not covered	20% <a href="#">coinsurance</a>	Not covered	*See <a href="#">preauthorization</a> schedule attached to your <a href="#">plan</a> document.
	<a href="#">Hospice services</a>	No charge	Not covered	30% <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		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             | • Private-duty nursing                           |
| • Bariatric surgery (unless medically necessary) | • Hearing aids        | • Routine eye care                               |
| • Cosmetic surgery                               | • Long-term care      | • Routine foot care (unless medically necessary) |
| • Dental care                                    | • Non-preferred drugs | • Weight loss programs                           |
| • Generic drugs                                  | • Preferred drugs     |  |

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

**INA!**

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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### 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*)

<b>Total Example Cost</b>	<b>\$ 12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$70</b>

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### 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*)

<b>Total Example Cost</b>	<b>\$ 5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$4,100
<b>The total Joe would pay is</b>	<b>\$4,400</b>

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$ 2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$0
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$210</b>

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.