



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 deductible?	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 deductible?	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 deductibles for specific services?	Yes. \$100 individual / \$300 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 deductibles.	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 out-of-pocket limit for this plan?	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 out-of-pocket limit?	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 network provider?	Yes. For a list of <a href="#">in-network providers</a> , see capbluecross.com 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 referral to see a specialist?	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
		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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Not covered	20% <u>coinsurance</u>	Not covered	None
	<u>Specialist</u> visit	Not covered	20% <u>coinsurance</u>	Not covered	None
	<u>Preventive care/screening/</u> immunization	No charge	20% <u>coinsurance</u>	No charge	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>	No charge	None
	Imaging (CT/PET scans, MRIs)	No charge	20% <u>coinsurance</u>	No charge	None
If you need drugs to treat your illness or condition. More information about <u>prescription drug coverage</u> 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
	<u>Specialty drugs</u>	No coverage for <u>specialty drug</u>			None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% <u>coinsurance</u>	25% <u>coinsurance</u>	No coverage for services at <u>out-of-network</u> ambulatory surgical facilities
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	No charge	*See <u>preauthorization</u> schedule attached to your <u>plan</u> document.
If you need immediate medical attention	<u>Emergency room care</u>	No charge	No charge	No charge	<u>Deductible</u> does not apply.
	<u>Emergency medical transportation</u>	Not covered	No charge	Not covered	<u>Deductible</u> does not apply.
	<u>Urgent care</u>	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.
If your child needs dental or eye care	<a href="#">Hospice services</a>	No charge	Not covered	30% <a href="#">coinsurance</a>	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
- Bariatric surgery (unless medically necessary)
- Cosmetic surgery
- Dental care
- Generic drugs
- Glasses
- Hearing aids
- Long-term care
- Non-preferred drugs
- Preferred drugs
- Private-duty nursing
- Routine eye care
- Routine foot care (unless medically necessary)
- Weight loss programs

### 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](#).

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## 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)

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

**Total Example Cost** \$ 12,700

#### 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)

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

**Total Example Cost** \$ 5,600

#### 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)

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

**Total Example Cost** \$ 2,800

#### 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.