



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 ? | \$500 individual / \$1,000 family in-network providers ; \$1,000 individual / \$2,000 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. Professional services with copays, in-network preventive services , emergency services or emergency medical transportation . | 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 \$3,300 individual / \$6,600 family; for out-of-network providers \$2,000 individual / \$6,000 family. | 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 . |

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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 |
|--|--|--|--|---|
| | | 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 after deductible for Facility Owned Labs, No charge, waive deductible for Independent Labs | 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 | Not covered | | None |
| | Preferred brand drugs | Not covered | | None |
| | Non-preferred brand drugs | Not covered | | None |
| | Specialty drugs | No coverage for specialty drug | | None |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 50% coinsurance | No coverage for services at out-of-network ambulatory surgical facilities |
| | Physician/surgeon fees | No charge | 20% 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 immediate medical attention | Emergency room care | \$100 copayment /service | \$100 copayment /service | Deductible does not apply. Copayment waived if admitted inpatient. |
| | Emergency medical transportation | No charge | No charge | Deductible does not apply. |
| | Urgent care | \$50 copayment /service | 20% coinsurance | Deductible does not apply for services at in-network providers . |
| 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 | 20% 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 | 30 visit limit per benefit period |
| | Habilitation services | \$40 copayment /visit | 20% coinsurance | 100 day limit per benefit period. |
| | Skilled nursing care | No charge | 50% coinsurance | *See preauthorization schedule attached to your plan document. |
| | Durable medical equipment | No charge | 20% coinsurance | None |
| | 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 | 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. 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 1-866-787-9872 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?

No

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 | \$500 |
| ■ 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 | \$500 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$570 |

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$500 |
| ■ 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 | \$500 |
| Copayments | \$200 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$4,100 |
| The total Joe would pay is | \$4,800 |

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$500 |
| ■ 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 | \$500 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$10 |
| The total Mia would pay is | \$810 |

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.