



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 1-800-216-9741. 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>	\$350 individual / \$700 family <a href="#">in-network providers</a> ; \$1,000 individual / \$2,000 family <a href="#">out-of-network providers</a> .	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> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Professional services with copays, <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. 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> \$8,150 individual / \$16,300 family; for <a href="#">out-of-network providers</a> \$3,000 individual / \$6,000 family combined <a href="#">out-of-pocket limit</a> for <a href="#">network</a> 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 (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$15 <a href="#">copayment</a> /visit	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$30 <a href="#">copayment</a> /visit	20% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	20% <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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	20% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	No charge	20% <a href="#">coinsurance</a>	*See <a href="#">preauthorization</a> schedule attached to your <a href="#">plan</a> document.
If you need drugs to treat your illness or condition. More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.magellanrx.com</a>	Generic drugs	\$10 copay (retail) / \$25 copay (mail)	Not covered	Prescription drugs are covered at In-Network pharmacies only Retail 31 day supply Mail 90 day supply Specialty 31 day supply For Maintenance Medications, only one original fill plus two refills are covered at retail. Subsequent refills are covered only through mail service.
	Preferred brand drugs	\$35 copay (retail) / \$85 copay (mail)	Not covered	
	Non-preferred brand drugs	\$50 copay (retail) / \$125 copay (mail)	Not covered	
	<a href="#">Specialty drugs</a>	20% to a maximum of \$150 per script (retail)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">coinsurance</a>	Services at <a href="#">out-of-network</a> ambulatory surgical facilities 20% <a href="#">coinsurance</a> .
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	*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>	\$150 <a href="#">copayment</a> /service	\$150 <a href="#">copayment</a> /service	<a href="#">Deductible</a> does not apply. <a href="#">Copayment</a> waived if admitted inpatient.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	<a href="#">Deductible</a> does not apply.
	<a href="#">Urgent care</a>	\$40 <a href="#">copayment</a> /service	20% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply for services at <a href="#">in-network providers</a> .

\*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 have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% <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>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copayment</a> /visit	20% <a href="#">coinsurance</a>	None
	Inpatient services	No charge	20% <a href="#">coinsurance</a>	None
If you are pregnant	Office visits	\$30 <a href="#">copayment</a> /visit	20% <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	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No charge	20% <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>	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>	\$25 <a href="#">copayment</a> /visit	20% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Habilitation services</a>	\$25 <a href="#">copayment</a> /visit	20% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	No charge	20% <a href="#">coinsurance</a>	100 day limit per benefit period.
	<a href="#">Durable medical equipment</a>	No charge	20% <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	20% <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](#).)

- |  |                  |  |
|--|------------------|--|
| • Bariatric surgery (unless medically necessary) | • Glasses        | • Routine eye care                               |
| • Cosmetic surgery                               | • Hearing aids   | • Routine foot care (unless medically necessary) |
| • Dental care                                    | • Long-term care | • 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     | • Non-emergency care when traveling outside the U.S. | • Private-duty nursing |
| • Infertility treatment |  |                        |

**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 BlueCross at 1-800-216-9741 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](#) \$350
- [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	\$350
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$420</b>

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

- The [plan's](#) overall [deductible](#) \$350
- [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	\$350
Copayments	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,100
<b>The total Joe would pay is</b>	<b>\$4,550</b>

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

- The [plan's](#) overall [deductible](#) \$350
- [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	\$350
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$660</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

- 1 Healthcare benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the BlueCross BlueShield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.