



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 (CBC) or 1-800-711-0917 (ESI). 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.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$500 individual / \$1,000 family participating <a href="#">providers</a> ; \$1,000 individual / \$2,000 family non-participating <a href="#">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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Professional services with copays, <a href="#">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> .
Are there <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For participating <a href="#">providers</a> \$4,075 individual / \$8,150 family for medical, and \$4,075 individual / \$8,150 family for prescription drug expenses; for non-participating <a href="#">providers</a> \$3,000 individual / \$6,000 family for medical.	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Pre-authorization penalties, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, health care, and prescriptions 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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For a list of participating <a href="#">providers</a> , see <a href="http://capbluecross.com">capbluecross.com</a> or call 1-800-962-2242. For a list of approved pharmacies for the prescription drug plan, visit <a href="http://express-scripts.com">express-scripts.com</a>	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.
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> .



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
		Participating Provider (You will pay the least)	Non-participating 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	\$30 <a href="#">copayment</a> /visit	20% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$50 <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 participating <a href="#">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 certificate of coverage.
If you need drugs to treat your illness or condition. More information about <a href="#">prescription drug coverage</a> is available at <a href="#">express-scripts.com</a>	Generic drugs	\$20 retail/ \$40 mail order	Not covered	Covers up to 30-day supply (retail prescription), 90-day supply (mail order prescription). Mandatory Generic, as appropriate. \$25 per member deductible.
	Preferred brand drugs	\$40 retail/ \$80 mail order	Not covered	
	Non-preferred brand drugs	\$80 retail/ \$160 mail order	Not covered	
	<a href="#">Specialty drugs</a>	Preferred and non-preferred specialty drugs are available for the copays listed previously	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">coinsurance</a>	Services at non-participating 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 certificate of coverage.
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>	\$50 <a href="#">copayment</a> /service	\$50 <a href="#">copayment</a> /service	

\*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
		Participating Provider (You will pay the least)	Non-participating 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 certificate of coverage.
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 <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	\$50 <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. *See <a href="#">preauthorization</a> schedule attached to your certificate of coverage.
	<a href="#">Rehabilitation services</a>	\$50 <a href="#">copayment/visit</a> for Physical, Occupational, Speech; No charge for Respiratory	20% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Habilitation services</a>	\$50 <a href="#">copayment/visit</a> for Physical, Occupational, Speech	20% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	No charge	20% <a href="#">coinsurance</a>	None
	<a href="#">Durable medical equipment</a>	No charge	20% <a href="#">coinsurance</a>	*See <a href="#">preauthorization</a> schedule attached to your certificate of coverage.
	<a href="#">Hospice services</a>	No charge	Not covered	None
	Children's eye exam	Not covered	Not covered	None
If your child needs dental or eye care	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       | • Hearing aids                                   |
| • Bariatric surgery | • Long-term care                                 |
| • Cosmetic surgery  | • Routine eye care                               |
| • Dental care       | • Routine foot care (unless medically necessary) |
| • Glasses           | • 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 [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**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 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 1-866-787-9872 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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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	\$ 12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$50
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$610

### 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>	\$500
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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	\$ 7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$1,660
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$2,220

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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	\$ 1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$440
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$940

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.

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P.O. Box 779880 Harrisburg, PA 17177-9880

800.417.7842 (TTY: 711), fax, 855.990.9001

[CRC@capbluecross.com](mailto:CRC@capbluecross.com)

If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW., Room 509F, HHH Building, Washington, D.C. 20201, Toll-free 800.368.1019, 800.537.7697 (TDD). Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

### Language assistance

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).

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무료 전화 통역 서비스 800.962.2242 (TTY: 711).

Per parlare con un interprete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711)

للتحدث مجانًا إلى مترجم للغتك، يرجى الاتصال بـ 800.962.2242 (الهاتف النصي: 711)

Pour parler à un interprète dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).

Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

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Aby porozmawiac z tłumaczem w języku polskim, prosze zadzwonic na numer darmowy telefonu 800.962.2242 (TTY: 711)

Pou pale avèk yon entèprèt nan lang ou grastis, rele nan 800.962.2242 (TTY: 711).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711)

Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).