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, go to https://www.capbluecross.com/sbcs or 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 or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$550 individual / $750 family participating providers; $1,000 individual / $2,000 family non-participating 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. The deductible starts over January 1st.
Are there services covered before you meet your deductible?	Yes. Professional services with copays, 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 above the individual/family deductible?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers $4,075 individual / $8,150 family for medical, and $4,075 individual / $8,150 family for prescription drug expenses. There is no total medical expense limit for non-participating providers.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Pre-authorization penalties, premiums, balance billing charges, health care and prescription drugs 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 participating providers, see capbluecross.com or call 1-800-962-2242. For a list of approved pharmacies for the prescription drug plan, visit express-scripts.com	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 (e.g. lab work or anesthesiologist). 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.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$30 copayment/visit	20% coinsurance after deductible	None
	Specialist visit	$30 copayment/visit	20% coinsurance after deductible	Acupuncture not covered. Chiropractic not covered after 30 visits.
	Preventive care/screening/ immunization	No charge	20% coinsurance after deductible	Deductible does not apply to services at participating 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 lab or tests.	20% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	No charge after deductible.	20% coinsurance after deductible	*See preauthorization schedule attached to your certificate of coverage.
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at express-scripts.com	Generic drugs	Retail - 10% of Discounted Cost (up to $25), Mail Order - 5% of Discounted Cost (up to $15)	Not covered	Covers up to 30-day supply (retail prescription), 90-day supply (mail order prescription). $25 per member deductible for Retail only.
	Formulary (Preferred) brand drugs	Retail - 20% of Discounted Cost (up to $50), Mail Order - 10% of Discounted Cost (up to $25)	Not covered	
	Non-formulary (Non-preferred) brand drugs	Retail - 25% of Discounted Cost (up to $50), Mail Order - 15% of Discounted Cost (up to $25)	Not covered	
	Specialty drugs	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 after deductible.	50% coinsurance after deductible	Services at non-participating ambulatory surgical facilities 50% coinsurance.
	Physician/surgeon fees	No charge after deductible.	20% coinsurance after deductible	*See preauthorization schedule attached to your certificate of coverage.
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.	$150 max/trip for Basic Life Support (BLS); $250 max/trip for Advanced Life Support (ALS)	Deductible waived for non-par providers. Additional EMT charges may not be covered.
	Urgent care	$45 copayment/service	$45 copayment/service	Deductible does not apply.

*For more information about preauthorization, see the requirements document at www.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements

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 after deductible.	50% coinsurance after deductible	Hospital limited to 120 days per disability. Preauthorization is required.
	Physician/surgeon fees	No charge after deductible.	20% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment/visit	20% coinsurance after deductible	None
	Inpatient services	No charge after deductible.	20% professional coinsurance after deductible. For substance abuse 50% facility coinsurance.	Combined with medical I/P 120 day limit.
If you are pregnant	Office visits	No charge after $30 initial office visit copay	20% coinsurance after deductible	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	No charge after deductible.	20% coinsurance after deductible	
	Childbirth/delivery facility services	No charge after deductible.	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	No charge after deductible.	50% coinsurance after deductible	90 visit limit. *See preauthorization schedule attached to your certificate of coverage.
	Rehabilitation services	$30 copayment/visit	20% coinsurance after deductible	----------none----------
	Habilitation services	$30 copayment/visit	20% coinsurance after deductible	
	Skilled nursing care	No charge after deductible.	50% coinsurance after deductible	Limited to 360 days per disability. Combined with medical I/P day limit.
	Durable medical equipment	No charge after deductible.	20% coinsurance after deductible	*See preauthorization schedule attached to your certificate of coverage.
	Hospice services	No charge after deductible.	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered under this health plan	Not covered under this health plan	None
	Children's glasses	Not covered under this health plan	Not covered under this health plan	None
	Children's dental check-up	Not covered under this health plan	Not covered under this health plan	None

*For more information about preauthorization, see the requirements document atwww.capbluecross.com/wps/wcm/connect/CBC-Public/CBC/Members/Preauthorization+Requirements

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 (unless medically necessary)	• Long-term care (e.g. nursing home)
• Cosmetic surgery	• Routine eye care (under this plan)
• Dental care (under this plan)	• Routine foot care (unless medically necessary)
• Glasses (under this plan)	• 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.
• Infertility testing	• Private-duty nursing

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 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 https://www.capbluecross.com/sbcs or call 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

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 plan's overall deductible	$550
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	$ 12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$550
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$640

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

The plan's overall deductible	$550
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	$ 7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$575
Copayments	$1,050
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,685

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

The plan's overall deductible	$550
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	$ 1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$550
Copayments	$280
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$830

The plan would be responsible for the other costs of these EXAMPLE covered services.

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P.O. Box 779880 Harrisburg, PA 17177-9880
800.417.7842 (TTY: 711), fax, 855.990.9001
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).
欲免费用本国语言洽询传译员，请拨电话800.962.2242 (TTY: 711).
Để nói chuyện với thông dịch viên bằng ngôn ngữ của quý vị không phải mất phí, xin gọi 800.962.2242 (TTY: 711).
Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).
Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).
무료 전화 통역 서비스 800.962.2242 (TTY: 711).
Per parlare con un interpete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711)

للتحدث مجانًا إلى مترجم للغتك، يرجى الاتصال بـ 800.962.224
(الهاتف النصى: 711)

Pour parler à un interpréter 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 tlumaczem w jezyku 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).