



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.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 deductible?</b>                             | \$625 individual / \$1,250 family <a href="#">in-network providers</a> ; \$1,250 individual / \$2,500 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 deductible?</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 deductibles for specific services?</b>                | No.   | You don't have to meet <a href="#">deductibles</a> for specific services.  |
| <b>What is the out-of-pocket limit for this plan?</b>              | For <a href="#">in-network providers</a> \$4,275 individual / \$8,550 family for medical, and \$4,275 individual / \$8,550 family for prescription drug expenses; for <a href="#">out-of-network providers</a> \$2,000 individual / \$4,000 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.  |
| <b>What is not included in the out-of-pocket limit?</b>            | 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> .  |
| <b>Will you pay less if you use a network provider?</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. 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. |
| <b>Do you need a referral to see a specialist?</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<br>(You will pay the least)  | Out-of-network Provider<br>(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       | \$20 <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="#">express-scripts.com</a> | Generic drugs  | \$25 retail/ \$45 mail order   | Not covered  | Covers up to 30-day supply (retail prescription), 90-day supply (mail order prescription). Mandatory Generic, as appropriate.   |
|   | Preferred brand drugs                                  | \$50 retail/ \$90 mail order   | Not covered  |   |
|   | Non-preferred brand drugs                              | \$100 retail/ \$180 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  | 50% <a href="#">coinsurance</a>                    | Services at <a href="#">out-of-network</a> ambulatory surgical facilities 50% <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>                    | \$100 <a href="#">copayment</a> /service   | \$100 <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>                            | \$45 <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<br>(You will pay the least) | Out-of-network Provider<br>(You will pay the most) |   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)        | No charge                                       | 50% <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                       | \$30 <a href="#">copayment</a> /visit           | 20% <a href="#">coinsurance</a>                    | None  |
|   | Inpatient services                        | No charge                                       | 50% <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                                       | 50% <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>   | \$30 <a href="#">copayment</a> /visit           | 20% <a href="#">coinsurance</a>                    | 30 visit limit per benefit period   |
|   | <a href="#">Habilitation services</a>     | \$30 <a href="#">copayment</a> /visit           | 20% <a href="#">coinsurance</a>                    |   |
|   | <a href="#">Skilled nursing care</a>      | No charge                                       | 50% <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.  |
| If your child needs dental or eye care                                    | <a href="#">Hospice services</a>          | No charge                                       | 20% <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                                     |  | 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
- Glasses
- Hearing aids
- Long-term care
- 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.
- 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](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 1-866-787-9872 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?** **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](#) \$625
- [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                       | \$625        |
| Copayments                        | \$40         |
| Coinsurance                       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$60         |
| <b>The total Peg would pay is</b> | <b>\$725</b> |

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

- The [plan's](#) overall [deductible](#) \$625
- [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                       | \$520          |
| Copayments                        | \$1,370        |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,910</b> |

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

- The [plan's](#) overall [deductible](#) \$625
- [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                       | \$625        |
| Copayments                        | \$320        |
| Coinsurance                       | \$0          |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$945</b> |

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

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### Capital BlueCross

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).

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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).

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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 مجاناً 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).