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 or call 1-888-428-2566 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000 individual / $2,000 family in-network providers; $1,750 individual / $3,500 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. In-network preventive services or emergency services.	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?	Yes, prescription plan deductible of $100/individual.	You have to meet the prescription plan deductible before copays apply.
What is the out-of-pocket limit for this plan?	For in-network providers $5,000 individual / $10,000 family; for out-of-network providers $7,500 individual / $15,000 family combined out-of-pocket limit for network medical and prescription drug.	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. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.
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.

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	$25 copayment/visit	20% coinsurance after deductible	None
	Specialist visit	$35 copayment/visit	20% coinsurance after deductible	None
	Preventive care/screening/ immunization	No charge	20% coinsurance after deductible	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)	10% coinsurance for Facility Owned Labs, 10% coinsurance for Independent Clinical Labs and 10% coinsurance for tests. 10% coinsurance for outpatient radiology.	20% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	20% coinsurance after deductible	*See preauthorization schedule attached to your plan document.
If you need drugs to treat your illness or condition. More information about	Generic drugs	Low Cost Generic $10 copay Retail; $25 copay Mail Order; Generic $15 copay Retail, $37 copay Mail Order	Not covered	$100 per individual pharmacy deductible. Retail copays listed are for up to a 31-day supply. Mail order copays listed are for up to a 90-day supply. Mail order scripts must be obtained through ESI Mail Order pharmacy. Maintenance medications may be obtained for 2 fills at Retail, after Maintenance Medications must be obtained through Express Scripts mail order pharmacy.
	Preferred brand drugs	$35 copay Retail; $87.50 copay Mail Order	Not covered	
	Non-preferred brand drugs	$65 copay Retail; $162.50 copay Mail Order	Not covered	

prescription drug coverage is available by calling RxBenefits at 800-334-8134	Specialty drugs	Specialty Generic & Preferred brand 10% coinsurance to $125 maximum; Non-preferred brand 20% coinsurance to $150 maximum	Not covered	Specialty medications must be obtained through Accredo and are limited to a 30-day supply. If you are contacted by SaveOnSP about your specialty medication and you do NOT enroll in the program, you will pay 30% coinsurance for the drug that would otherwise qualify for the SaveOnSP program. Please see "Important Questions: regarding the plans out-of-pocket limit.

*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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance Acute Care Hospital and 10% coinsurance Ambulatory Surgical Center; coinsurance applies after deductible	20% coinsurance after deductible	Services at out-of-network ambulatory surgical facilities 20% coinsurance.
	Physician/surgeon fees	10% coinsurance after deductible	20% coinsurance after deductible	*See preauthorization schedule attached to your plan document.
If you need immediate medical attention	Emergency room care	$200 copayment/service	$200 copayment/service	Deductible does not apply. Copayment waived if admitted inpatient.
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	None
	Urgent care	$45 copayment/service	20% coinsurance after deductible	Deductible does not apply for services at in-network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	20% coinsurance after deductible	*See preauthorization schedule attached to your plan document.
	Physician/surgeon fees	10% coinsurance after deductible	20% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copayment/visit	20% coinsurance after deductible	None
	Inpatient services	10% coinsurance after deductible	20% coinsurance after deductible	None
If you are pregnant	Office visits	$35 copayment/visit	20% coinsurance after deductible	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	10% coinsurance after deductible	20% coinsurance after deductible	
	Childbirth/delivery facility services	10% coinsurance after deductible	20% coinsurance after deductible	
	Home health care	10% coinsurance after deductible	20% coinsurance after deductible	90 visit limit per benefit period. *See preauthorization schedule attached to your plan document.
	Rehabilitation services	Physical Therapy: $25 copayment; Speech and Occupational Therapies: $35 copayment	20% coinsurance after deductible	----------none----------

If you need help recovering or have	Habilitation services	Physical Therapy: $25 copayment; Speech and Occupational Therapies: $35 copayment	20% coinsurance after deductible	----------none----------

*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)	
other special health needs	Skilled nursing care	10% coinsurance after deductible	20% coinsurance after deductible	100 day limit per benefit period.
	Durable medical equipment	10% coinsurance after deductible	20% coinsurance after deductible	*See preauthorization schedule attached to your plan document.
	Hospice services	10% coinsurance after deductible	20% coinsurance after deductible	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		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. 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 1-800-216-9741 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

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	$1,000
Specialist copayment	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$1,000
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	$2,170

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

The plan's overall deductible	$1,000
Specialist copayment	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$1,000
Specialist copayment	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$900
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$1,310

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

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If you believe that Capital Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email at:

Capital Blue Cross
PO 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 interprete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711)

للتحدث مجانا الى مترجم للغتك، يرجى الاتصال بـ 800.962.2242 (الهاتف النصي: 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).

 દુભાષીયા જોડે વાત કરવા, 800.962.2242 (TTY: 711) પર ફોન કરો.

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).

ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្តាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711)

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

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