



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 ?	\$1,700 individual / \$3,400 family. Deductible applies to all services, including prescription drug , before any copayment or coinsurance are applied.	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 , the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. In-network preventive 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For in-network providers \$6,900 individual / \$13,800 family; for out-of-network providers \$3,000 individual / \$6,000 family combined out-of-pocket limit for 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.	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 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	None
	Specialist visit	\$35 copayment /visit	20% coinsurance	None
	Preventive care/screening/immunization	No charge	20% coinsurance	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	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	*See preauthorization schedule attached to your plan document.

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 need drugs to treat your illness or condition. More information about prescription drug coverage is available by calling RxBenefits at 800-334-8134	Generic drugs	Retail: Low Cost Generic: \$10 copay; Generic: \$15 copay; Retail 90-day supply: Low Cost Generic \$30 copay; Generic: \$45 copay Mail Order 90-day supply: Low Cost Generic: \$25 copay;	Not covered	<p>Medical & pharmacy deductible are combined. Copayments apply after the deductible is met.</p> <p>Select Weight Loss/Non-GLP-1 Medications; \$150 copay after Rx deductible for 1-month supply; \$450 copay after Rx deductible for 90-day supply.</p>
	Preferred brand drugs	Retail: \$35 copay; Retail 90-day supply: \$105 copay Mail Order 90-day supply: \$87.50 copay	Not covered	
	Non-preferred brand drugs	Retail: \$65 copay; Retail 90-day supply: \$195 copay Mail Order 90-day supply: \$162.50 copay	Not covered	
	Specialty drugs	Specialty Generic & Preferred brand 10% coinsurance to \$125 maximum; Non-preferred brand 20% coinsurance to \$150 maximum	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory)	10% coinsurance Acute Care	20% coinsurance	Services at out-of-network ambulatory
	Physician/surgeon fees	10% coinsurance	20% coinsurance	*See preauthorization schedule attached to your plan document.

*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 need immediate medical attention	Emergency room care	\$200 copayment /service	\$200 copayment /service	Copayment waived if admitted inpatient.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	\$45 copayment /service	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	*See preauthorization schedule attached to your plan document.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance	Outpatient services	\$35 copayment /visit	20% coinsurance	None
	Inpatient services	10% coinsurance	20% coinsurance	None
If you are pregnant	Office visits	\$35 copayment /visit	20% coinsurance	Depending on the type of services, a copayment , coinsurance , or deductible may apply.
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	90 visit limit per benefit period. *See preauthorization schedule attached to your plan document.
	Rehabilitation services	Physical Therapy: \$25	20% coinsurance	-----none-----
	Habilitation services	Physical Therapy: \$25 copayment ; Speech and	20% coinsurance	
	Skilled nursing care	10% coinsurance	20% coinsurance	100 day limit per benefit period.
	Durable medical equipment	10% coinsurance	20% coinsurance	*See preauthorization schedule attached to
	Hospice services	10% coinsurance	20% coinsurance	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 | • Glasses | • Preferred drugs |
| • Bariatric surgery (unless medically necessary) | • Hearing aids | • Routine eye care |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---------------------|--|------------------------|
| • Chiropractic care | • Non-emergency care when traveling outside the U.S. | • Private-duty nursing |
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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?

No

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	\$1,700
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,700
Copayments	\$0
Coinsurance	\$1,100
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$2,870

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

■ The plan's overall deductible	\$1,700
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,300
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$4,100
The total Joe would pay is	\$5,400

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

■ The plan's overall deductible	\$1,700
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,700
Copayments	\$100
Coinsurance	\$70
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$1,880

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

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