**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?** | $3,500 individual / $7,000 family in-network providers; $6,000 individual / $12,000 family out-of-network providers. 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, 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. | 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 $8,050 individual / $16,100 family; for out-of-network providers $10,000 individual / $20,000 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 | 20% coinsurance after deductible | 30% coinsurance after deductible | None |
| | Specialist visit | 20% coinsurance after deductible | 30% coinsurance after deductible | None |
| | Preventive care/screening/ immunization | No charge | 30% 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) | 20% coinsurance for Facility Owned Labs, 20% coinsurance after deductible for Independent Clinical Labs and 20% coinsurance after deductible for tests. 20% coinsurance after deductible for outpatient radiology. | 30% coinsurance after deductible | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | 30% coinsurance after deductible | *See preauthorization schedule attached to your plan document. |
| **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 | 20% coinsurance after deductible | Not covered | The medical & rx deductible is combined; the deductible must be met before coinsurance applies. Retail coinsurance if for a 31-day supply; Mail Order coinsurance is for a 90-day supply. For maintenance medications, one 31-day fill plus 2 refills are covered at Retail. Subsequent refills are covered only through Mail Order. Specialty Drugs are covered through Accredo. |
| | Preferred brand drugs | 20% coinsurance after deductible | Not covered | |
| | Non-preferred brand drugs | 20% coinsurance after deductible | Not covered | |
| | Specialty drugs | 20% coinsurance after deductible | Not covered | |

| | | | | |
|---|---|---|---|---|
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible Acute Care Hospital and 20% coinsurance after deductible Ambulatory Surgical Center | 30% coinsurance after deductible | Services at out-of-network ambulatory surgical facilities 30% coinsurance. |
| | Physician/surgeon fees | 20% coinsurance after deductible | 30% coinsurance after deductible | *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 | 20% coinsurance after deductible | 20% coinsurance after deductible | None |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after deductible | None |
| | Urgent care | 20% coinsurance after deductible | 30% coinsurance after deductible | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | 30% coinsurance after deductible | *See preauthorization schedule attached to your plan document. |
| | Physician/surgeon fees | 20% coinsurance after deductible | 30% coinsurance after deductible | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance after deductible | 30% coinsurance after deductible | None |
| | Inpatient services | 20% coinsurance after deductible | 30% coinsurance after deductible | None |
| **If you are pregnant** | Office visits | 20% coinsurance after deductible | 30% coinsurance after deductible | Depending on the type of services, a copayment, coinsurance, or deductible may apply. |
| | Childbirth/delivery professional services | 20% coinsurance after deductible | 30% coinsurance after deductible | |
| | Childbirth/delivery facility services | 20% coinsurance after deductible | 30% coinsurance after deductible | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance after deductible | 30% coinsurance after deductible | 90 visit limit per benefit period. *See preauthorization schedule attached to your plan document. |
| | Rehabilitation services | 20% coinsurance after deductible | 30% coinsurance after deductible | ----------none---------- |
| | Habilitation services | 20% coinsurance after deductible | 30% coinsurance after deductible | |
| | Skilled nursing care | 20% coinsurance after deductible | 30% coinsurance after deductible | 100 day limit per benefit period. |
| | Durable medical equipment | 20% coinsurance after deductible | 30% coinsurance after deductible | *See preauthorization schedule attached to your plan document. |
| | Hospice services | 20% coinsurance after deductible | 30% 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.) | | |
|---|---|---|
| • Bariatric surgery (unless medically necessary) | • Glasses | • Routine eye care |
| • Cosmetic surgery | • Hearing aids | • Routine foot care (unless medically necessary) |
| • Dental care | • Long-term care | • 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<br>• 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** | $3,500 |
| **Specialist copayment** | $0 |
| **Hospital (facility) coinsurance** | 20% |
| **Other coinsurance** | 20% |

**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 | $3,500 |
| Copayments | $0 |
| Coinsurance | $1,700 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **The total Peg would pay is** | $5,270 |

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

| | |
|---|---|
| **The plan's overall deductible** | $3,500 |
| **Specialist copayment** | $0 |
| **Hospital (facility) coinsurance** | 20% |
| **Other coinsurance** | 20% |

**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 | $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** | $3,500 |
| **Specialist copayment** | $0 |
| **Hospital (facility) coinsurance** | 20% |
| **Other coinsurance** | 20% |

**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 | $2,400 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| **The total Mia would pay is** | $2,410 |

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.