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 1-888-428-2566. 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 https://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?	$1,975 individual / $3,950 family in-network providers; $3,950 individual / $7,900 family out-of-network providers	Generally, you must pay all of 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. Deductible applies to all services, including prescription drug, before any copayment or coinsurance are applied.
Are there services covered before you meet your deductible?	Yes. In-network preventive services and in-network and out-of-network COVID-19 testing and immunization are covered before you meet your deductible until the end of the COVID-19 Public Health Emergency.	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 other 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?	$4,000 individual / $8,000 family in-network providers; $8,000 individual / $16,000 family out-of-network providers. 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Preauthorization penalties, 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 www.capbluecross.com or call 1-800-962-2242. For information on participating pharmacies, visit www.caremark.com or call 1-888-528-7458.	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		Limitations, 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	10% coinsurance	30% coinsurance	COVID-19 testing and immunization is covered at no charge in-network and out-of-network until the end of the COVID-19 Public Health Emergency.
	Specialist visit	10% coinsurance	30% coinsurance	
	Preventive care/screening/ immunization	No charge; deductible does not apply	30% coinsurance	Age and frequency schedules may apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance for Facility Owned Labs; 10% coinsurance for Independent Clinical Labs, tests, and outpatient radiology	50% coinsurance for Facility Owned Labs; 30% coinsurance for Independent Clinical Labs, tests and outpatient radiology	COVID-19 testing and immunization is covered at no charge in-network and out-of-network until the end of the COVID-19 Public Health Emergency.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	*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 at www.caremark.com or by calling 1-888-528-7458	Generic drugs	Retail: $10 copayment/ prescription. Mail Order: $20 copayment/ prescription	Not covered	Covers 30-day supply (retail prescription), 90-day supply (mail order prescription or at CVS). For Maintenance medications after 3 fills if you do not move to a 90 day supply you pay 100% of the cost. PPACA preventive drugs at no charge unless a member requests a brand when a generic is available.
	Preferred brand drugs	Retail: $25 copay/ prescription. Mail Order: $50 copayment/ prescription	Not covered	
	Non-preferred brand drugs	Retail: $40 copayment/ prescription. Mail Order: $80 copayment/ prescription	Not covered	

* For more information about preauthorization, see the requirements document at www.capbluecross.com/preauthorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Specialty drugs	$100 copayment/ prescription	Not covered	Covers up to a 30-day supply retail or home delivery. Specialty drugs include biotech, injectable, and other medications used for many critical conditions.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance Acute Care Hospital; 10% coinsurance Ambulatory Surgical Center	Acute Care Hospital: 50% coinsurance; Ambulatory Surgical Center: not covered.	No coverage for services at out-of-network ambulatory surgical facilities.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	*See preauthorization schedule attached to your plan document.
If you need immediate medical attention	Emergency room care	Covered in full after deductible	Covered in full after deductible	COVID-19 testing and immunization is covered at no charge in-network and out-of-network until the end of the COVID-19 Public Health Emergency.
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	10% coinsurance	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	*See preauthorization schedule attached to your plan document.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	None
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	90 visit limit per benefit period. *See preauthorization schedule attached to your plan document.
	Rehabilitation services	10% coinsurance	30% coinsurance	30 visit limit per benefit period

* For more information about preauthorization, see the requirements document at www.capbluecross.com/preauthorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
	Habilitation services	10% coinsurance	30% coinsurance	Physical, Occupational and Speech Therapies 30 visits each per benefit period combined with Rehabilitation
	Skilled nursing care	10% coinsurance	30% coinsurance	100 day limit per benefit period
	Durable medical equipment	10% coinsurance	30% coinsurance	*See preauthorization schedule attached to your plan document.
	Hospice services	10% coinsurance	30% 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	Not covered	None

* For more information about preauthorization, see the requirements document at 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	• Routine eye care
• Bariatric surgery (unless medically necessary)	• Hearing aids	• Routine foot care (unless medically necessary)
• Cosmetic surgery	• Long-term care	• Weight loss programs
• Dental care	• Private-duty nursing	

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.

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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gove/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 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 1-888-428-2566, 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 the 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.*

* For more information about preauthorization, see the requirements document at www.capbluecross.com/preauthorization.

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	**$1,975**
Specialist copayment	**$0**
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	$1,975
Copayments	$10
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,145**

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

The plan's overall deductible	**$1,975**
Specialist copayment	**$0**
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	$1,975
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,595**

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

The plan's overall deductible	**$1,975**
Specialist copayment	**$0**
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	$1,975
Copayments	$0
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,025**

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

NONDISCRIMINATION AND FOREIGN LANGUAGE ASSISTANCE NOTICE

Capital Blue Cross and its family of companies comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Capital Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Capital Blue Cross provides free aids and services to people with disabilities or whose primary language is not English, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic format, other formats), and qualified interpreters, and information written in other languages. If you need these services, call 800.962.2242 (TTY: 711).

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)
711: (الهاتف النصي) 800.962.2242 للتحدث مجانًا إلى مترجم للغتك، يرجى الاتصال بـ
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).
ગુજરાતીમા 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).
ដើម្បីនិយាយជាមួយអ្នកបកប្រែផ្ទាល់មាត់ជាភាសារបស់អ្នកដោយមិនគិតថ្លៃ សូមហៅទៅកាន់ 800.962.2242 (TTY: 711)
Para falar com um intérprete em seu idioma de graça, ligue para 800.962.2242 (TTY: 711).