




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, www.capitoladm.com or call 1-877-789-8488 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 Uniform Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Network : \$1,500/Individual / \$3,000/family Non-network : \$3,000/individual / \$6,000/family	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 , 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. Preventive care , in-network office visits and true medical emergency facility charges	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, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan ?	For network providers \$4,500 individual / \$9,000 family For non- network providers \$9,000 individual / \$18,000/family	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 ?	Copayments for certain services, 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. Call 1-877-916-2525 or visit www.blueshieldca.com/networkppo to find a provider in CA. For all other providers, call 1-877-916-2525 or visit www.provider.bcbs.com .	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.	This plan will pay the costs to see a specialist for covered services without permission from this plan.

 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
		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 copay /office visit	40% coinsurance	None
	Specialist visit Applies to Chiropractic Care	\$40 copay /office visit	40% coinsurance	None
	Preventive care/screening/immunization	No charge, deductible waived	40% coinsurance deductible waived	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	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.flexscripts.com or call 1-800-603-7796	Generic drugs (Tier 1)	\$10 copay /retail \$20 copay /mail order	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Prenatal vitamins are covered at 100%.
	Preferred brand drugs (Tier 2)	\$30 copay /retail \$60 copay /mail order	Not covered	
	Non-preferred brand drugs (Tier 3)	\$45 copay /retail \$90 copay /mail order	Not covered	
	Specialty drugs (Tier 4)	50% coinsurance up to maximum copay of \$200/prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	\$200 copay	\$200 copay	Copay is waived if admitted; Network deductible applies to Out-of-Network benefits
	Emergency medical transportation	20% coinsurance	20% coinsurance	Network deductible applies to Out-of-Network benefits
	Urgent care	\$40 copay /visit	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay /office visit and 20% coinsurance for other outpatient services	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	1st visit/No charge 20% coinsurance thereafter	40% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required
	Rehabilitation services	20% coinsurance	40% coinsurance	35 visits/calendar year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	20% coinsurance	40% coinsurance	None
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 180 days/calendar year. Preauthorization is required.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	No charge	40% coinsurance	Preauthorization is required. Coverage is limited to 5 days of respite care maximum per 21-day period.
If your child needs dental or eye care	Children's eye exam	\$25 copay /visit	40% coinsurance	Coverage limited to one routine vision exam/calendar year. Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.
	Children's glasses	Not covered	Not covered	No coverage
	Children's dental check-up	Not covered	Not covered	Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.

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 .)		
<ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery	<ul style="list-style-type: none">• Dental Care• Infertility Treatment	<ul style="list-style-type: none">• Private Duty Nursing• Routine foot care• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• Chiropractic Care• Hearing aids (limited to one per ear every 36 months)	<ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside US	<ul style="list-style-type: none">• Routine eye care

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 : DOL, Employee Benefit Directly Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: Lucent Health Solutions, LLC at PO Box 7020 Appleton, WI 54912-7020 or call 877-236-0844.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-331-5301.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-331-5301.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-331-5301.

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-331-5301.

—————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	\$1500
■ Specialist copayment	\$40
■ 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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1500
Copayments	\$90
Coinsurance	\$2,480
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,130

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1500
■ Specialist copayment	\$40
■ 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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$1500
Copayments	\$980
Coinsurance	\$372
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$2,907

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1500
■ Specialist copayment	\$40
■ 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	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$1305
Copayments	\$120
Coinsurance	\$326
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1751