
 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 1-800-807-0400 or visit us at www.myCBS.org/health or email at hbscustomerservice@cbservices.org. 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 1-800-807-0400 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<p>Medical Only In-Network \$500 Individual / \$1,000 Family</p> <p>Medical Only Out-of-Network \$750 Individual / \$2,100 Family</p> <p>In-Network & Out-of-Network <u>deductibles</u> do not reduce each other.</p>	<p>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.</p>
Are there services covered before you meet your deductible?	<p>Yes. For <u>preventive care</u> services, the In-Network <u>deductible</u> does not apply</p>	<p>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/.</p>
Are there other deductibles for specific services	<p>No</p>	<p>You don't have to meet deductibles for specific services.</p>
What is the out-of-pocket limit for this plan?	<p>Combined Medical & Prescription Drug In-Network \$1,500 Individual / \$3,000 Family</p> <p>Medical Only Out-of-Network \$3,500 Individual / \$7,000 Family</p> <p>In-Network & Out-of-Network <u>out-of-pocket limits</u> do not reduce each other.</p>	<p>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.</p>
What is not included in out-of-pocket limit	<p><u>Premiums</u>, <u>balance-billed</u> charges, <u>deductible</u>, <u>copayment</u>, or <u>coinsurance</u> amounts paid on a covered persons behalf by a foundational or manufacturer sponsored patient assistance program, penalty for prescription retail refill allowances, penalty for mandatory</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits.</p>

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Important Questions	Answers	Why This Matters:
	generics, penalty for non-notification of hospital admission and other services requiring pre-certification, and health care this plan does not cover.	
Will you pay less if you use a <u>network provider</u>?	Yes. Your <u>network</u> is BlueCross BlueShield. See myCBS.org/ppo-hcsc or call 1-800-810-2583 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 (You will pay the least)	Out of Network (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copayment</u> /Visit; <u>Deductible</u> does not apply	40% <u>coinsurance</u>	Includes Virtual Care (via video or voice).
	<u>Specialist</u> visit	\$25 <u>copayment</u> /Visit; <u>Deductible</u> does not apply	40% <u>coinsurance</u>	Includes Virtual Care (via video or voice). In-Network Allergy injections \$10 <u>copayment</u> / visit; <u>deductible</u> does not apply.
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab Work - No charge Radiology - 10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to services performed outside physician's office. Payment may differ based on place of service.
	Imaging (CT/PET)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to services performed outside physician's

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
	scans, MRIs)			office. Payment may differ based on place of service. Precertification is required. A 25% penalty up to \$300 may apply. Penalty does not apply to out-of-pocket limit.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myCBS.org/health Log in and click on My Prescription Drugs or call Express Scripts at 800-718-6601. More information about the Smart 90, Generics Member Pays The Difference, <u>Formulary</u> , Retail Refill Allowance and SaveonSP programs is available at: www.myCBS.org/Rx	Generic drugs	\$10 /Prescription (retail); \$25 /Prescription (mail or Smart90)	Same as In-Network +20% <u>coinsurance</u> penalty	<u>Deductible</u> does not apply. Covers up to 30-day supply at retail; 90-day supply mail order or Smart90 prescription. Retail maintenance prescriptions are limited to an initial fill and two refills. If you continue to use retail, outside of the Smart 90 program, you will pay the mail order <u>copayment</u> for a 30-day supply. You may fill a 90-day supply at Walgreens owned retail pharmacies through the Smart90 program. If a generic equivalent is available and a brand-name medication is dispensed for any reason, you will pay the difference in cost plus the brand <u>copayment</u> .
	Preferred brand drugs	\$25 /Prescription (retail); \$60 /Prescription (mail or Smart90)	Same as In-Network +20% <u>coinsurance</u> penalty	
	Non-preferred brand drugs	\$40 /Prescription (retail); \$100 /Prescription (mail or Smart90)	Same as In-Network +20% <u>coinsurance</u> penalty	
	<u>Specialty drugs</u>	Generic 10% up to maximum of \$150 Preferred 20% up to maximum of \$150 Non-Preferred 20% up to maximum of \$250 Certain specialty pharmacy drugs are considered non-essential health benefits and copayments may be set to the maximum of above or any available manufacturer-funded copay assistance. For a complete list of non-essential specialty medications, see mycbs.org/health/SaveonSP		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center, hospital)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to services performed outside physician's office. You may be billed amounts in excess of prevailing charges for <u>Out-of-Network Providers</u> . Precertification is required. A 25% penalty up to \$300 may apply. Penalty does not apply to <u>out-of-pocket limit</u> .
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u> - Facility fee	10% <u>Coinsurance</u> after \$150 <u>Copayment/Admission</u> ;	10% <u>Coinsurance</u> after \$150 <u>Copayment/Admission</u> ;	Copayment is waived if admitted.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
		<u>Deductible</u> does not apply	<u>Deductible</u> does not apply	
	<u>Emergency room care</u> - Physician/surgeon fees	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Emergency room care</u> may include tests and services described elsewhere in the SBC (i.e. <u>Diagnostic tests</u> or Imaging.) You may be billed amounts in excess of prevailing charges for <u>Out-of-Network Providers</u> .
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	For transportation service charges exceeding \$5,000 by ground and/or air, payment will not exceed 150% of Medicare allowance for such incurred expenses. Charges include transportation and medical supplies used during transport.
	<u>Urgent care</u>	\$25 <u>copayment</u> /Visit; <u>Deductible</u> does not apply	40% <u>coinsurance</u>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification is required.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	Inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification is required.
If you are pregnant	Office visits	\$25 <u>copayment</u> /Visit; <u>Deductible</u> does not apply	40% <u>coinsurance</u>	Copayment applies to initial prenatal visit only (per pregnancy). Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 100 visits per plan year maximum.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	<u>Habilitation services</u>	Specialist- \$25 copayment/Visit; <u>Deductible</u> does not apply Outpatient Facility- 10% <u>coinsurance</u>	40% <u>coinsurance</u>	Payment may differ based on place of service. Limited to a combined 20 visits per year for all providers , including, but not limited to, physical, occupational and speech therapy. Visit limits apply to Habilitation services only.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 120 days for all confinements maximum resulting from the same or a related illness or injury.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Check your plan document for limitations. Orthotics – Limited to \$500 lifetime.
	<u>Hospice services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 180 days per plan year maximum.
If your child needs dental or eye care	Children's eye exam	No charge	40% <u>coinsurance</u>	Covered up to age 5.
	Children's glasses	Not covered	Not covered	Unless covered by your vision plan .
	Children's dental check-up	Not covered	Not covered	Unless covered by your dental plan .

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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](#).)

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|-----------------------|--|-----------------------------|
| • Contraceptives | • Hearing aids and related charges | • Routine eye care (Adult) |
| • Cosmetic surgery | • Infertility treatment (except initial diagnosis) | • Routine foot care |
| • Dental care (Adult) | • Long-term care | • Sterilization or Abortion |
| • Eye exam over age 5 | • Private-duty nursing | • Weight loss programs |

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

- Bariatric Surgery
- Habilitation services (payable per medical necessity)
- Services provided by State Licensed Practitioners within the scope of license not specifically covered under any other provisions of the medical plan, including Acupuncture, Massage Therapy, and Nutritional Counseling – Limited to 12 combined visits per year for all services
- Chiropractic care (payable per medical necessity as specialist MD)
- Non-emergency care when traveling outside the U.S. (only when on assignment by ER)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. Church plans are not covered by the Federal COBRA continuation coverage rules. For more information on your rights to continue coverage, contact the plan at 1-800-807-0400. You may also contact your state insurance department. 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: the plan at 1-800-807-0400. A list of states with Consumer Assistance Programs is available at <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>

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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-807-0400.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-807-0400.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-807-0400.

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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-807-0400.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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Calendar Year January 1

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)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)
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| <ul style="list-style-type: none"> ■ The plan's overall deductible \$500 ■ Specialist copayment \$25 ■ Hospital (facility) coinsurance 10% ■ Other coinsurance 10% | <ul style="list-style-type: none"> ■ The plan's overall deductible \$500 ■ Specialist copayment \$25 ■ Hospital (facility) coinsurance 10% ■ Other coinsurance 10% | <ul style="list-style-type: none"> ■ The plan's overall deductible \$500 ■ Specialist copayment \$25 ■ Hospital (facility) coinsurance 10% ■ Other coinsurance 10% |
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<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>	<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>	<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>
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Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
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In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$500	Deductibles	\$500	Deductibles	\$500
Copayments	\$0	Copayments	\$600	Copayments	\$300
Coinsurance	\$1,000	Coinsurance	\$50	Coinsurance	\$200
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$40
The total Peg would pay is	\$1,560	The total Joe would pay is	\$1,170	The total Mia would pay is	\$1,040

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

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