
 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 1-844-552-7806. 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.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-final.pdf> or call 1-844-552-7806 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers – \$600 person / \$1,300 family Non-Network Providers – \$700 person / \$2,100 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. Network office visits and some Network preventive care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. Prescription drugs: \$50 person / \$100 family Dental: \$50 per person (Doesn't apply to preventive services.)	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network Providers – \$3,000 per person Non-Network Providers - \$6,000 per person	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 each have to meet their own out-of-pocket limits .
What is not included in the out-of-pocket limit?	Deductible, copayments, premiums, balance-billed charges, cost containment penalties, health care this plan doesn't cover, dental, vision and prescription drug charges (except for Rx deductibles).	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. See www.anthem.com or call 1-800-810-2583 for a list of network providers.	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
		Network Provider (You will pay the least)	Non-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	\$35 copay for the first \$200 in charges per office visit then 20% coinsurance (deductible waived) on charges over \$200.	40% coinsurance	Office visits include diagnostic lab and X-ray performed in the physician's office. Teladoc services: no charge. Call 1-800-835-2362 or visit www.teladoc.com .
	Specialist visit	\$50 copay for the first \$200 in charges per office visit then 20% coinsurance (deductible waived) on charges over \$200.	40% coinsurance	Office visits include diagnostic lab and X-ray performed in the physician's office.
	Preventive care/screening/immunization	No charge per office visit for Adult preventive care; \$35 copay per office visit for children up to age 18.	40% coinsurance	Preventive care does not include colonoscopies. 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)	Physician office: \$35 copay for the first \$200 in charges per office visit then 20% coinsurance (deductible waived) on charges over \$200 Freestanding facility or independent lab: 20% coinsurance	40% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	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)	Non-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available from HealthSmart Rx at 1-800-681-6912 or www.healthsmart.com</p>	Generic drugs	\$15 copay – retail (30 day) \$25 copay – retail (90 day) \$20 copay – mail order	If an Out-of-Network retail pharmacy is used	<p>A separate deductible will apply to prescription drugs per calendar year: \$50 person / \$100 family. Retail – 30 to 90 day supply, Mail order – 30 to 90 day supply.</p> <p>If a Generic is available and allowed by the Physician, the individual will be required to pay the Brand copay and the difference in cost between the Generic and Brand name if Brand is chosen (applies to both Retail and Mail Order prescriptions).</p> <p>Specialty drugs require prior authorization and are limited to a 30 day supply per fill. One fill is allowed at a retail pharmacy, subsequent fills must be made through Briova Specialty Rx. Call HealthSmart Rx 1-800-681-6912.</p>
	Preferred brand drugs	\$25 copay – retail (30 day) \$35 copay – retail (90 day) \$30 copay – mail order	the participant will pay the full cost of the prescription up front and	
	Non-preferred brand drugs	\$35 copay – retail (30 day) \$50 copay – retail (90 day) \$45 copay – mail order	file a paper claim to HealthSmart Rx for	
	Specialty drugs	25% up to a maximum out-of-pocket of \$500 then applicable retail copay will apply.	reimbursement minus the applicable copay .	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	<p>Precertification is required. If not obtained, benefit payment will be reduced by 50%. Call HealthSmart 1-877-202-6379.</p> <p>-----none-----</p>
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
<p>If you need immediate medical attention</p>	Emergency room care	\$100 copay per visit then 20% coinsurance	\$100 copay per visit then 20% coinsurance	Copay amount is waived if patient is admitted to the hospital from the ER. Non-emergent use of a non-network facility: \$100 copay then 40% coinsurance .
	Emergency medical transportation	20% coinsurance	20% coinsurance	-----none-----
	Urgent care	20% coinsurance	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)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification is required. If not obtained, benefit payment will be reduced by 50%. Call HealthSmart 1-877-202-6379.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$35 copay for the first \$200 in charges per office visit then 20% coinsurance (deductible waived) on charges over \$200. All other outpatient services: 20% coinsurance	40% coinsurance	-----none-----
	Inpatient services	20% coinsurance	40% coinsurance	Precertification is required. If not obtained, benefit payment will be reduced by 50%. Call HealthSmart 1-877-202-6379.
If you are pregnant	Office visits	Routine prenatal office visit: \$35 copay for the first \$200 in charges per office visit then 20% coinsurance (deductible waived) on charges over \$200. All other outpatient services: 20% coinsurance	40% coinsurance	Not covered for dependent children.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Not covered for dependent children.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Precertification is required for maternity stays longer than 48 hours (or 96 hours for cesarean delivery). If not obtained, benefit payment will be reduced by 50%. Call HealthSmart 1-877-202-6379. Not covered for dependent children.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 40 visits per calendar year.
	Rehabilitation services	Occupational and speech therapy: 20% coinsurance Physical therapy: \$25 copay per visit	40% coinsurance	Includes therapy services such as occupational, physical and speech therapy. Physical therapy is limited to 20 visits per calendar year.
	Habilitation services			
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 60 days per calendar year. Precertification is required. If not obtained, benefit payment will be reduced by 50%. Call HealthSmart 1-877-202-6379.
	Durable medical equipment	20% coinsurance	40% coinsurance	-----none-----
	Hospice services	20% coinsurance	40% coinsurance	-----none-----
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to \$245 per person, per calendar year for all eligible vision care charges combined. Includes frames, lenses, contacts, and eye exams.
	Children's glasses	No charge	No charge	
	Children's dental check-up	No charge	No charge	Limited to 2 cleanings per calendar year.

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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|---|---|---|
| <ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Hearing aids | <ul style="list-style-type: none">• Infertility treatment (Except for care, supplies and services for initial diagnosis.)• Long-term care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Private-duty nursing• Routine foot care• Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---|---|--|
| <ul style="list-style-type: none">• Bariatric surgery (for morbid obesity)• Chiropractic care (limit \$1,000 per year) | <ul style="list-style-type: none">• Dental care | <ul style="list-style-type: none">• Routine eye care |
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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. For more information on your rights to continue coverage, contact the [plan](#) at 1-775-738-5196. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security 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 the Claims Administrator at 1-844-552-7806. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

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 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 1-844-552-7806. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-552-7806. Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-552-7806.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-552-7806.

—————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](#) \$600
- [Specialist copayment](#) \$50
- 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:

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$490
Coinsurance	\$1,910
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

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

- The [plan's](#) overall [deductible](#) \$600
- [Specialist copayment](#) \$50
- 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:

<i>Cost Sharing</i>	
Deductibles	\$650
Copayments	\$1,170
Coinsurance	\$350
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,225

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

- The [plan's](#) overall [deductible](#) \$600
- [Specialist copayment](#) \$50
- 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:

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$250
Coinsurance	\$285
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,135