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/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-uniform-glossary-of-coverage-and-medical-terms-new.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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from HealthSmart Rx at 1-800-681-6912 or www.healthsmart.com	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 the participant will pay the full cost of the prescription up front and file a paper claim to HealthSmart Rx for reimbursement minus the applicable copay.	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. 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).
	Preferred brand drugs	$25 copay – retail (30 day) $35 copay – retail (90 day) $30 copay – mail order		
	Non-preferred brand drugs	$35 copay – retail (30 day) $50 copay – retail (90 day) $45 copay – mail order		
	Specialty drugs	25% up to a maximum out-of-pocket of $500 then applicable retail copay will apply.		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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	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 immediate medical attention	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.)

- Acupuncture
- Cosmetic surgery
- Hearing aids
- Infertility treatment (Except for care, supplies and services for initial diagnosis.)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Bariatric surgery (for morbid obesity)
- Chiropractic care (limit $1,000 per year)
- Dental care
- Routine eye care

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

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 1-844-552-7806. 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, kwiijigo 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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$490
Coinsurance	$1,910
What isn't covered	
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$650
Copayments	$850
Coinsurance	$100
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,655**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$250
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,150**

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