




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 HS&BA at (800) 635-3105. 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 1-800-635-3105 to request a copy.

| Important Questions  | Answers  | Why This Matters:  |
|--|--|--|
| <b>What is the overall deductible?</b>                             | PPO <u>providers</u> and Non-PPO <u>providers</u> combined: <b>\$1,000/individual or \$2,000/family.</b>   | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .  |
| <b>Are there services covered before you meet your deductible?</b> | Yes. PPO <u>preventive care</u> , LiveHealth online visit and outpatient <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .  | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> |
| <b>Are there other deductibles for specific services?</b>          | There are no specific <u>deductibles</u> under your medical <u>plan</u> . (Depending on the dental option that your employer bargains for, you may have a <u>deductible</u> under a separate dental <u>plan</u> .)   | Under this medical <u>plan</u> , you don't have to meet <u>deductibles</u> for specific services.  |
| <b>What is the out-of-pocket limit for this plan?</b>              | <b>Medical PPO providers:</b> \$2,000/individual, \$4,000/family.<br><b>Outpatient Prescription Drugs</b> (in-network): \$2,000/individual; \$4,000/family.  | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have 2 or more other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.  |
| <b>What is not included in the out-of-pocket limit?</b>            | <b>Medical:</b> <u>Balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> , amounts over the reference-based price, dental & vision expenses, health care this <u>plan</u> doesn't cover, Non-PPO <u>copayments</u> and <u>coinsurance</u> except for ER visit, and out-of-area expenses.<br><b>Outpatient Prescription Drugs:</b> medical, dental, and vision expenses, <u>balance-billing</u> charges, charges for certain brand drugs if a generic is available, penalties for failure to obtain <u>preauthorization</u> , health care this <u>plan</u> doesn't cover, and expenses from an out-of- <u>network</u> or out-of-area pharmacy. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |

| Important Questions  | Answers   | Why This Matters:   |
|--|---|---|
| Will you pay less if you use a <u>network provider</u> ?   | Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-810-BLUE for a list of PPO <u>providers</u> . | You pay the least if you use a <u>provider</u> in the Anthem Prudent Buyer PPO network. You pay more if you use a <u>provider</u> that is an Out-of-Area Provider (as you will be <u>balance-billed</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   |
|---|--|--|--|--|--|
|   |  | PPO Provider (You will pay the least)                                  | Out-of-Area Provider                               | Non-PPO Provider (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 | Office Visit: 15% <u>coinsurance</u>                                   | 15% <u>coinsurance</u> plus <u>balance billing</u> | 35% <u>coinsurance</u> plus <u>balance billing</u> | None.  |
|   | <u>Specialist</u> visit                          | LiveHealth Online: \$20 copay/visit; <u>deductible</u> does not apply. |  |  |  |
|   | <u>Preventive care/screening/Immunization</u>    | No charge, <u>deductible</u> does not apply                            | Not covered  | Not covered  | <ul style="list-style-type: none"> <li>You may have to pay for services that aren't <u>preventive care</u>. Ask your <u>provider</u> if the services needed are <u>preventive</u>. Then check what your <u>plan</u> will pay for.</li> <li>For colonoscopies and sigmoidoscopies received from a Non-PPO or out-of-area provider, you pay 35% <u>coinsurance</u> after <u>deductible</u>, plus any <u>balance billing</u> that any Non-PPO provider may charge you.</li> </ul> |

| Common Medical Event  | Services You May Need                          | What You Will Pay  |   |  | Limitations, Exceptions, & Other Important Information  |
|---|--|--|---|--|---|
|   |  | PPO Provider (You will pay the least)  | Out-of-Area Provider  | Non-PPO Provider (You will pay the most)   |   |
| If you have a test  | Diagnostic test (x-ray, blood work)            | 15% <u>coinsurance</u>   | 15% <u>coinsurance</u> plus <u>balance billing</u>                  | 35% <u>coinsurance</u> plus <u>balance billing</u>   | Professional/physician charges may be billed separately.  |
|   | Imaging (CT/PET scans, MRIs)                   | 15% <u>coinsurance</u>   | 15% <u>coinsurance</u> plus <u>balance billing</u>                  | 35% <u>coinsurance</u> plus <u>balance billing</u>   | <u>Preauthorization</u> required for repeat imaging to avoid non-payment. Professional/physician charges may be billed separately.  |
| If you need drugs to treat your illness or condition<br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> | Generic drugs                                  | Retail (30-day supply) \$5 <u>copay</u> /script plus 20% <u>coinsurance</u> , Mail order (90-day supply): \$40 <u>copay</u> /script          | You must pay 100% <u>coinsurance</u> and file a claim with the PBM. |  | <ul style="list-style-type: none"> <li>• <u>Deductible</u> does not apply to <u>prescription drugs</u>.</li> <li>• Certain generic over-the-counter (OTC) and <u>prescription drugs</u> are payable at no charge with a prescription.</li> <li>• Some <u>prescription drugs</u> are subject to preapproval, quantity limits or step therapy.</li> <li>• No charge for FDA-approved generic contraceptives (or brand name if generic is medically inappropriate)</li> <li>• Max <u>copay</u> of \$100 per brand name drug if unavailable or medically inappropriate as generic or through mail order.</li> <li>• Excluded amounts do not count towards the <u>out-of-pocket limit</u>.</li> <li>• Your <u>cost sharing</u> counts toward the <u>prescription drug out-of-pocket limit</u>, not the medical <u>plan out-of-pocket limit</u>.</li> </ul> |
|   | Preferred brand drugs                          | Retail (30-day supply) 20% <u>coinsurance</u> ; Mail order (90-day supply): \$60 <u>copayment</u> /script                                    |   |  |   |
|   | Non-preferred brand drugs                      | Retail (30-day supply) \$15 <u>copayment</u> /script plus 20% <u>coinsurance</u> , Mail order (90-day supply): \$60 <u>copayment</u> /script |   |  |   |
|   | <u>Specialty drugs</u>                         | 20% <u>coinsurance</u> up to \$100 maximum <u>copayment</u>  | Not covered   | <ul style="list-style-type: none"> <li>• Limited to a 30-day supply.</li> <li>• <u>Deductible</u> does not apply.</li> <li>• <u>Specialty drugs</u> must be filled using the OptumRx Specialty Mail Order Pharmacy. Call 1-877-839-7045.</li> <li>• Your <u>cost sharing</u> counts toward the <u>prescription drug out-of-pocket limit</u>, not the medical <u>plan out-of-pocket limit</u>.</li> </ul> |   |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center) | 15% <u>coinsurance</u>   | 15% <u>coinsurance</u> plus any amount over \$500                   | 35% <u>coinsurance</u> plus any amount over \$500  | For hospital facility charge at a PPO <u>provider</u> , max of \$6,000 is payable for an arthroscopy, \$2,000 for cataract surgery, and \$1,500 for colonoscopy.  |

| Common Medical Event  | Services You May Need                   | What You Will Pay  |  |  | Limitations, Exceptions, & Other Important Information  |
|---|---|--|--|--|---|
|   |   | PPO Provider (You will pay the least)  | Out-of-Area Provider   | Non-PPO Provider (You will pay the most)   |   |
|   | Physician/surgeon fees                  | 15% <u>coinsurance</u>   | 15% <u>coinsurance</u> plus <u>balance billing</u>   | 35% <u>coinsurance</u> plus <u>balance billing</u>   | Services of a Non-PPO anesthesiologist or assistant surgeon may be covered as a PPO provider if a PPO hospital and PPO surgeon are used.  |
| If you need immediate medical attention                                   | <u>Emergency room care</u>              | 15% <u>coinsurance</u>   | 15% <u>coinsurance</u> plus <u>balance billing</u>   | 35% <u>coinsurance</u> plus <u>balance billing</u>   | Professional/physician charges may be billed separately.  |
|   | <u>Emergency medical transportation</u> | 15% <u>coinsurance</u>   | 15% <u>coinsurance</u> plus <u>balance billing</u>   | 35% <u>coinsurance</u> plus <u>balance billing</u>   | You pay 100% for Non-emergency ambulance, even <u>In-network</u> .  |
|   | <u>Urgent care</u>                      | 15% <u>coinsurance</u>   | 15% <u>coinsurance</u> plus <u>balance billing</u>   | 35% <u>coinsurance</u> plus <u>balance billing</u>   | None.   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)      | 15% <u>coinsurance</u>   | 15% <u>coinsurance</u> plus <u>balance billing</u>   | 35% <u>coinsurance</u> plus <u>balance billing</u>   | <u>Preauthorization</u> is required to avoid a \$250 penalty. Payment will be limited to a \$30,000 maximum for a single hip or knee replacement surgery. Hospital semi-private room is covered.  |
|   | Physician/surgeon fees                  | 15% <u>coinsurance</u>   | 15% <u>coinsurance</u> plus <u>balance billing</u>   | 35% <u>coinsurance</u> plus <u>balance billing</u>   | None.   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                     | <b>Office Visit:</b> 15% <u>coinsurance</u><br><b>LiveHealth Online:</b> \$20 <u>copayment</u> /visit; <u>deductible</u> does not apply.<br><b>Other Outpatient Services:</b> 15% <u>coinsurance</u> | 15% <u>coinsurance</u> plus <u>balance billing</u>   | 35% <u>coinsurance</u> plus <u>balance billing</u>   | None.   |
|   | Inpatient services                      | 15% <u>coinsurance</u>   | 15% <u>coinsurance</u> plus <u>balance billing</u>   | 35% <u>coinsurance</u> plus <u>balance billing</u>   | <u>Preauthorization</u> is required to avoid a \$250 penalty. Hospital semi-private room is covered.  |
| If you are pregnant   | Office visits                           | 15% <u>coinsurance</u>   | Preventive prenatal <u>screenings</u> are not covered. All other services 15% <u>coinsurance</u> plus <u>balance billing</u> | Preventive prenatal <u>screenings</u> are not covered. All other services 35% <u>coinsurance</u> plus <u>balance billing</u> | <ul style="list-style-type: none"> <li>• <u>Cost sharing</u> does not apply for <u>preventive services</u> from PPO <u>providers</u>.</li> <li>• Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).</li> </ul> |

| Common Medical Event   | Services You May Need                     | What You Will Pay                     |  |  | Limitations, Exceptions, & Other Important Information   |
|--|---|---------------------------------------|--|--|--|
|  |   | PPO Provider (You will pay the least) | Out-of-Area Provider                               | Non-PPO Provider (You will pay the most)           |  |
|  | Childbirth/delivery professional services | 15% <u>coinsurance</u>                | 15% <u>coinsurance</u> plus <u>balance billing</u> | 35% <u>coinsurance</u> plus <u>balance billing</u> | <ul style="list-style-type: none"> <li>• <u>Preauthorization</u> is required to avoid a \$250 penalty only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section.</li> <li>• Hospital semi-private room is covered.</li> <li>• Ultrasound payable as a diagnostic test.</li> </ul> |
|  | Childbirth/delivery facility services     | 15% <u>coinsurance</u>                | 15% <u>coinsurance</u> plus <u>balance billing</u> | 35% <u>coinsurance</u> plus <u>balance billing</u> |  |
| If you need help recovering or have other special health needs | <u>Home health care</u>                   | 15% <u>coinsurance</u>                | 15% <u>coinsurance</u> plus <u>balance billing</u> | 35% <u>coinsurance</u> plus <u>balance billing</u> | 150 visits per calendar year.  |
|  | <u>Rehabilitation services</u>            | 15% <u>coinsurance</u>                | 15% <u>coinsurance</u> plus <u>balance billing</u> | 35% <u>coinsurance</u> plus <u>balance billing</u> | 12 (or in some cases 24) visits per calendar year. <u>Preauthorization</u> of inpatient rehabilitation services is required to avoid a \$250 penalty.  |
|  | <u>Habilitation services</u>              | Not covered                           | Not covered  | Not covered  | You must pay 100% of this service, even in <u>network</u> .  |
|  | <u>Skilled nursing care</u>               | 15% <u>coinsurance</u>                | 15% <u>coinsurance</u> plus <u>balance billing</u> | 35% <u>coinsurance</u> plus <u>balance billing</u> | 120 days per disability  |
|  | <u>Durable medical equipment</u>          | 15% <u>coinsurance</u>                | 15% <u>coinsurance</u> plus <u>balance billing</u> | 35% <u>coinsurance</u> plus <u>balance billing</u> | Rental is covered unless purchase is less expensive  |
|  | <u>Hospice services</u>                   | 15% <u>coinsurance</u>                | 15% <u>coinsurance</u> plus <u>balance billing</u> | 35% <u>coinsurance</u> plus <u>balance billing</u> | Covered for terminally ill patient   |
| If your child needs dental or eye care                         | Children's eye exam                       | Not covered                           | Not covered  | Not covered  | If your employer provides vision coverage, it will be under a separate vision <u>plan</u> .  |
|  | Children's glasses                        | Not covered                           | Not covered  | Not covered  |  |
|  | Children's dental check-up                | Not covered                           | Not covered  | Not covered  | If your employer provides dental coverage, it will be under a separate dental <u>plan</u> .  |

### 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 <u>excluded services</u> .)   |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult) (Child) (may be offered under a separate dental <u>plan</u>)</li> <li>• <u>Habilitation services</u></li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids (for employee or spouse)</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult) (Child) (may be covered under separate vision <u>plan</u>)</li> <li>• Weight loss programs (except as required by the health reform law)</li> </ul> |

**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"><li>• Acupuncture (12 visits/calendar year for pain)</li><li>• Bariatric Surgery (Gastric bypass covered if approved by Utilization Management)</li></ul> | <ul style="list-style-type: none"><li>• Chiropractic care (12 visits/calendar year)</li><li>• Hearing aids (for dependent children only, max \$400 per aid payable once every 36 months)</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment (only services to diagnose infertility are covered)</li><li>• Routine foot care</li></ul> |
|---|--|---|

**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.gov/ebsa/healthreform](http://www.dol.gov/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](http://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 Health Services & Benefit Administrators at (800) 635-3105. 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](http://www.dol.gov/ebsa/healthreform).

**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 (800) 635-3105.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 635-3105.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 635-3105.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 635-3105.

————— *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 **\$2,000**
- Specialist coinsurance **15%**
- Hospital (facility) coinsurance **15%**
- Other coinsurance **15%**

**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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,000        |
| Copayments                        | \$20           |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$10           |
| <b>The total Peg would pay is</b> | <b>\$2,030</b> |

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

- The plan's overall deductible **\$2,000**
- Specialist coinsurance **15%**
- Hospital (facility) coinsurance **15%**
- Other coinsurance **15%**

**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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$900          |
| Copayments                        | \$150          |
| Coinsurance                       | \$1,160        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$260          |
| <b>The total Joe would pay is</b> | <b>\$2,470</b> |

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

- The plan's overall deductible **\$1,000**
- Specialist coinsurance **15%**
- Hospital (facility) coinsurance **15%**
- Other coinsurance **15%**

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,930        |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,930</b> |

**NOTE:** These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your cost. For more information about the wellness program, please contact HS&BA at (800) 635-3105.