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:
What is the overall deductible?	PPO providers and Non-PPO providers combined: **$200**/individual or **$400**/family (**$400**/individual or **$800**/family in 2024 if you did not participate in the wellness program in 2023).	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. PPO preventive care, LiveHealth online visit and outpatient prescription drugs 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. 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.
What is the out-of-pocket limit for this plan?	***Medical* PPO providers**: $1,500/individual, $4,500/family of 3 or more. ***Outpatient Prescription Drugs*** (in-network): $1,500/individual; $4,500/family of 3 or more.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have 2 or more 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?	***Medical***: Balance-billing charges, penalties for failure to obtain preauthorization, amounts over the reference-based price, dental & vision expenses, health care this plan doesn't cover, Non-PPO copayments and coinsurance except for ER visit, and out-of-area expenses. ***Outpatient Prescription Drugs:*** medical, dental, and vision expenses, balance-billing charges, charges for certain brand drugs if a generic is available, penalties for failure to obtain preauthorization, health care this plan doesn't cover, and expenses from an out-of-network or out-of-area pharmacy.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 1-800-810-BLUE for a list of PPO providers.	You pay the least if you use a provider in the Anthem Prudent Buyer PPO network. You pay more if you use a provider that is an Out-of-Area Provider (as you will be balance-billed). 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
		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 provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	LiveHealth Online: $20 copay/visit; deductible does not apply.
	Specialist visit				
	Preventive care/screening/ immunization	No charge, deductible does not apply	Not covered	Not covered	• You may have to pay for services that aren't preventive care. Ask your provider if the services needed are preventive. Then check what your plan will pay for. • For colonoscopies and sigmoidoscopies received from a Non-PPO or out-of-area provider, you pay 35% coinsurance after deductible, plus any balance billing that any Non-PPO provider may charge you.

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% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	Professional/physician charges may be billed separately.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	• Preauthorization 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 More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Retail (30-day supply) $5 copay/script plus 20% coinsurance; Mail order (90-day supply): $40 copay/script	You must pay 100% coinsurance and file a claim with the PBM.		• Deductible does not apply to prescription drugs. • Certain generic over-the-counter (OTC) and prescription drugs are payable at no charge with a prescription. • Some prescription drugs are subject to preapproval, quantity limits or step therapy. • No charge for ACA-required generic preventive care drugs (such as contraceptives) or brand name drugs if a generic is medically inappropriate. • Max copay of $100 per brand name drug if unavailable or medically inappropriate as generic or through mail order. • Excluded amounts do not count towards the out-of-pocket limit. • Your cost sharing counts toward the prescription drug out-of-pocket limit, not the medical plan out-of-pocket limit.
	Preferred brand drugs	Retail (30-day supply) 20% coinsurance; Mail order (90-day supply): $60 copay/script			
	Non-preferred brand drugs	Retail (30-day supply) $15 copay/script plus 20% coinsurance; Mail order (90-day supply): $60 copay/script			

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)	
	Specialty drugs	20% coinsurance up to $100 maximum copay	Not covered		• Limited to a 30-day supply. • Deductible does not apply. • Specialty drugs must be filled using the OptumRx Specialty Mail Order Pharmacy. Call 1-877-839-7045. • Your cost sharing counts toward the prescription drug out-of-pocket limit, not the medical plan out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	15% coinsurance plus any amount over $500	35% coinsurance plus any amount over $500	For hospital facility charge at a PPO provider, maximum of $6,000 is payable for an arthroscopy, $2,000 for cataract surgery, and $1,500 for colonoscopy.
	Physician/surgeon fees	15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	• 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. • Balance billing will not apply if services were provided at a PPO facility unless a consent waiver was signed.
If you need immediate medical attention	Emergency room care	15% coinsurance	15% coinsurance	15% coinsurance	Professional/physician charges may be billed separately.
	Emergency medical transportation	15% coinsurance	15% coinsurance plus balance billing	15% coinsurance plus balance billing	• You pay 100% for Non-emergency ambulance, even In-network. • Balance billing will not apply to covered air ambulance services.
	Urgent care	15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	Preauthorization is required to avoid a $250 penalty. Payment will be limited to a $35,000 maximum for a single hip or knee replacement surgery. Hospital semi-private room is covered.
	Physician/surgeon fees	15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	None.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	**Office Visit**: 15% coinsurance **Other Outpatient Services**: 15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	LiveHealth Online: $20 copay/visit; deductible does not apply.
	Inpatient services	15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	Preauthorization is required to avoid a $250 penalty. Hospital semi-private room is covered.
If you are pregnant	Office visits	15% coinsurance	Preventive prenatal screenings are not covered. All other services 15% coinsurance plus balance billing	Preventive prenatal screenings are not covered. All other services 35% coinsurance plus balance billing	• Cost sharing does not apply for preventive services from PPO providers. • Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	• Preauthorization 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. • Hospital semi-private room is covered. • Ultrasound payable as a diagnostic test.
	Childbirth/delivery facility services	15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	150 visits per calendar year.
	Rehabilitation services	15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	12 (or, in some cases, an additional 24 visits) per calendar year. Preauthorization of inpatient rehabilitation services is required to avoid a $250 penalty.
	Habilitation services	15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	Coverage limited to medically necessary treatment of autism or other covered mental health diagnosis. Other services are not covered by the plan.
	Skilled nursing care	15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	120 days per disability
	Durable medical equipment	15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	Rental is covered unless purchase is less expensive

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)	
	Hospice services	15% coinsurance	15% coinsurance plus balance billing	35% coinsurance plus balance billing	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 plan.
	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 plan.

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.)

- Cosmetic surgery
- Dental care (Adult) (Child) (may be offered under a separate dental plan)
- Habilitation services (except for medically necessary treatment of autism or other covered mental health diagnosis)
- Hearing aids (for employee or spouse)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult) (Child) (may be covered under separate vision plan)
- Weight loss programs (except as required by the health reform law)

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

- Acupuncture (12 visits/calendar year for pain)
- Bariatric Surgery (Gastric bypass covered if approved by Utilization Management)
- Chiropractic care (12 visits/calendar year)
- Hearing aids (for dependent children only, max $400 per aid payable once every 36 months)
- Infertility treatment (only services to diagnose infertility are covered)
- Routine foot 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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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 on how 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.

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 (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, kwiijigo 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** **$400**
- **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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$10
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,530**

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

- **The plan's overall deductible** **$400**
- **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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$90
Coinsurance	$920
What isn't covered	
Limits or exclusions	$160
The total Joe would pay is	**$1,570**

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

- **The plan's overall deductible** **$400**
- **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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$10
Coinsurance	$360
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$770**

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.