




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, www.myhealthbenefits.com. 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 1-866-995-2450 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network: \$6,950 / Individual \$13,900 / Family Out-of-Network: \$13,900 / Individual \$27,800 / 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. Prescription copayments, in-network physician office visits, and Preventive care .	This plan covers items and services without meeting a deductible . But a copayment or coinsurance may apply. For example, this plan 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 ?	In-Network: \$6,950 / Individual \$13,900 / Family Out-of-Network: \$20,850 / Individual \$41,700 / Family	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 , the overall family members in this plan they must 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 ?	Premiums , balance-billing charges, penalties for preauthorization for services, and health care this plan doesn't cover.	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 1-866-995-2450 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

Important Questions	Answers	Why This Matters:
		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, unless otherwise indicated.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-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	0% coinsurance	50% coinsurance	Telemedicine with your primary physician or specialist will be cover the same as any other office visit.
	Specialist visit	0% coinsurance	50% coinsurance	Telemedicine with your primary physician or specialist will be cover the same as any other office visit.
	Preventive care/screening/immunization	0% coinsurance	50% coinsurance	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. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	Preauthorization is required. If you do not obtain preauthorization from the plan benefits will be reduced by 25%.
If you need drugs to treat your illness or condition	Generic drugs	Retail: 0% coinsurance Mail Order: 0% coinsurance		Certain medications considered preventative care under ACA are payable at no cost-share to the member.

Important Questions	Answers	Why This Matters:		
<p>More information about prescription drug coverage is available at www.anthem.com</p> <p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.anthem.com</p>	Preferred brand drugs	Retail: 0% coinsurance Mail Order: 0% coinsurance		<p>Retail: up to a 90-day supply Mail Order: up to a 90-day supply All contraceptives covered at 100%. Maintenance drugs must be filled through mail order – CarelonRx.</p>
	Non-preferred brand drugs	Retail: 0% coinsurance Mail Order: 0% coinsurance		
	Specialty drugs	0% coinsurance		<p>Specialty drugs must be filled through CarelonRx. Case Management required.</p>
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	Some procedures may require preauthorization .
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
<p>If you need immediate medical attention</p>	Emergency room care	0% coinsurance	Covered as In-Network	Copayment does not apply if admitted.
	Emergency medical transportation	0% coinsurance	Covered as In-Network	<p>Preauthorization is required for non-emergency ambulance services.</p> <p>You are responsible for balance billing if not a true emergency.</p>
	Urgent care	0% coinsurance	50% coinsurance	None
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Preauthorization is required
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None

Important Questions	Answers	Why This Matters:		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	50% coinsurance	Preauthorization required for some services
	Inpatient services	0% coinsurance	50% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	0% coinsurance	50% coinsurance	Cost sharing does not apply to preventive services .
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Professional fees rendered in a facility setting are covered at 100% after deductible .
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	Preauthorization is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	Preauthorization is required
	Rehabilitation services	0% coinsurance	50% coinsurance	Includes physical, speech, occupational, and other rehabilitative therapies. Cardiac therapy is limited to 40 visits/year. Pulmonary therapy is limited to 30 visits/year. Physical, speech, and occupational therapy limited to 24 visits/year. Additional visits may be approved if medically necessary.
	Habilitation services	0% coinsurance	50% coinsurance	None
	Skilled nursing care	0% coinsurance	50% coinsurance	Preauthorization is required Maximum of 180 days per Calendar Year .
	Durable medical equipment	0% coinsurance	50% coinsurance	Preauthorization is required
	Hospice services	0% coinsurance	50% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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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|-------------------------|---|------------------------|
| • Cosmetic Surgery | • Infertility Treatment | • Private Duty Nursing |
| • Dental Care | • Long-term care | • Routine eye care |
| • Hearing Aids | • Non-Emergency care when traveling outside of the U.S. | • Routine foot care |
| • Habilitation Services | | • Weight Loss Programs |

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

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| • Acupuncture (Maximum 12 visits per Calendar Year) | • Bariatric Surgery | • Chiropractor (\$1,000 maximum per Calendar Year) |
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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. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: BRMS at 1-866-995-2450 or myhealthbenefits.com or 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 1-866-995-2450.

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](#) \$500
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 10%
- Other (generic drug) [copayment](#) \$10

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$10
Coinsurance	\$1,060
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,630

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 10%
- Other (brand drug) [copayment](#) \$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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$120
Copayments	\$540
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$680

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$850
- [Specialist copayment](#) \$35
- Hospital (facility) [coinsurance](#) 10%
- Other (generic drug) [coinsurance](#) \$10

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$130
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$830

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