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?	**$0 /** Individual **$0 /** 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.gove/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: **$1,500 /** Individual **$3,000 /** Family Pharmacy: **$7,200** / individual and **$14,400** / family (no more than $**1,000** in mail order 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, 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 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	**No.**	You can see the specialist you choose without a referral.

Important Questions	Answers	Why This Matters:
see a specialist?		

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	$10/visit	Not covered	Telemedicine with your primary physician or specialist will be cover the same as any other office visit.
	Specialist visit	$10/visit	Not covered	Telemedicine with your primary physician or specialist will be cover the same as any other office visit.
	Preventive care/screening/ immunization	No Charge	Not covered	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.gove/coverage/preventive-care-benefits/.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No Charge	Not covered	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**: $5/prescription **Mail Order**: $10/prescription	Not applicable	Certain medications considered preventative care under ACA are payable at no cost-share to the member.

Important Questions	Answers	Why This Matters:		
More information about **prescription drug coverage** is available at **www.anthem.com** **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at **www.anthem.com**	Preferred brand drugs	**Retail**: $20/prescription **Mail Order**: $40/prescription	Not applicable	**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.**
	Non-preferred brand drugs	**Retail**: $50/prescription **Mail Order**: $100/prescription	Not applicable	
	Specialty drugs	20% coinsurance up to $250/prescription	Not applicable	Specialty drugs must be filled through **CarelonRx**. Case Management required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not covered	Some procedures may require preauthorization.
	Physician/surgeon fees	No Charge	Not covered	None
If you need immediate medical attention	Emergency room care	$50 / visit	Covered as in-network	Copayment does not apply if admitted.
	Emergency medical transportation	No Charge	Covered as in-network	Preauthorization is required for non-emergency ambulance services. You are responsible for balance billing if not a true emergency.
	Urgent care	$10/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not covered	Preauthorization is required
	Physician/surgeon fees	No Charge	Not covered	None

Important Questions	Answers	Why This Matters:		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10/visit	Not covered	Preauthorization required for some services
	Inpatient services	No Charge	Not covered	Preauthorization is required.
If you are pregnant	Office visits	No Charge	Not covered	Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	No Charge	Not covered	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	No Charge	Not covered	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	No Charge	Not covered	Preauthorization is required
	Rehabilitation services	$10 / visit	Not covered	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	$10 / visit	Not covered	None
	Skilled nursing care	No Charge	Not covered	Preauthorization is required Maximum of 180 days per Calendar Year.
	Durable medical equipment	No Charge	Not covered	Preauthorization is required
	Hospice services	No Charge	Not covered	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.)

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

- Acupuncture (Maximum 12 visits per Calendar Year)
- Bariatric Surgery
- Chiropractor ($1,000 maximum per Calendar Year)

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	**$0**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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

The plan's overall deductible	**$0**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$0
Copayments	$410
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$430**

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

The plan's overall deductible	**$0**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	$0
Copayments	$110
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$110**

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