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, contact HealthComp at 1-800-442-7247. 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 1-800-442-7247 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	Network Provider *Per Calendar Year* $250/Individual $750/Family	Out-of-Network Provider *Per Calendar Year* $1,000/Individual $3,000/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 emergency room, urgent care, primary care office visits, specialist office visits, mental health/substance use disorder office visits, allergy testing & serum & injections, contraceptives, chemotherapy, home infusion therapy, diagnostic test, pre-admission testing, rehabilitation services, acupuncture, chiropractic, preventive care and Network and Non-Network diabetic education.		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?	Network Provider *Per Calendar Year* $2,000/Individual $6,000/Family	Out-of-Network Provider *Per Calendar Year* $4,000/Individual $8,000/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, 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?	Premiums, balance-billing charges, cost containment penalties 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 1-800-442-7247 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	$20/visit Deductible waived	40% coinsurance	None
	Specialist visit	$40/visit Deductible waived	40% coinsurance	None
	Preventive care/screening/ immunization	No Charge Deductible waived	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$20/visit Deductible waived	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by $500.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

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 at www.flexscripts.com/	Generic drugs	**Retail 30 days** $15/prescription **Mail or Retail 100 days** $30/prescription	**Retail 30 days** $30/prescription **Retail only 100 days** $60/prescription	Non-Network Mail Order: No benefit
	Preferred brand drugs	**Retail 30 days** $30/prescription **Mail or Retail 100 days** $60/prescription	**Retail 30 days** $60/prescription **Retail only 100 days** $120/prescription	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	Same Retail copay as indicated above for 30 day fill	Not Covered	Specialty drugs available through Noble Health Services call 1-888-843-2040.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by $500.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$100/visit Deductible waived	$100 visit + 40% coinsurance	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50/visit Deductible waived	$50 visit + 40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100/admission + 20% coinsurance	$100/admission + 40% coinsurance	Precertification is required for certain services. If you don't get precertification, benefits could be reduced by $500.
	Physician/surgeon fees	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 mental health, behavioral health, or substance abuse services	Outpatient services	**Office Setting** $20/visit Deductible waived **Outpatient** 20% coinsurance	40% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by $500.
	Inpatient services	$100/admission + 20% coinsurance	$100/admission + 40% coinsurance	Precertification is required for certain services. If you don't get precertification, benefits could be reduced by $500.
If you are pregnant	Office visits	No charge Deductible waived	40% coinsurance	Cost-sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). When precertification is required, if you don't get precertified, benefits could be reduced by $500.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$100/admission + 20% coinsurance	$100/admission + 40% coinsurance	Precertification is only required for stay exceeding 48 hours after delivery (or 96 hours after C-section.).
If you need help recovering or have other special health needs **If you need help recovering or have other special health needs**	Home health care	20% coinsurance	40% coinsurance	130 visits per Calendar Year. Precertification is required. If you don't get precertification, benefits could be reduced by $500.
	Rehabilitation services	$20/visit Deductible waived	40% coinsurance	50 visits per Calendar Year per therapy. Visit limit is for Rehabilitation and Habilitation services combined. These limits do not apply to Habilitation services for the treatment of autism spectrum disorders.
	Habilitation services	$20/visit Deductible waived	40% coinsurance	
	Skilled nursing care	$100 day + 20% coinsurance	$100 day + 40% coinsurance	100 days per Calendar Year. Precertification is required. If you don't get precertification, benefits could be reduced by $500.
	Durable medical equipment	20% coinsurance	20% coinsurance	Precertification may be required for certain services. If you don't get precertification, benefits could be reduced by $500.
	Hospice services	20% coinsurance	40% coinsurance	Includes up to 3 bereavement counseling sessions.

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 your child needs dental or eye care	Children's eye exam	Not Covered		Must enroll in separate vision plan.
	Children's glasses	Not Covered		Must enroll in separate vision plan.
	Children's dental check-up	Not Covered		Must enroll in 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)
- Hearing Aids
- Infertility Treatment (except for diagnosis of infertility)
- 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.)

- Acupuncture (20 visits per calendar year combined with Chiropractic)
- Bariatric Surgery (when performed at a Centers of Excellence; limited to one per lifetime)
- Chiropractic Care (20 visits per calendar year combined with Acupuncture)
- Routine eye care (Adult – limited to 1 per 12 month period)

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 (for ERISA Plans): HealthComp at 800-442-7247 or 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 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: HealthComp 1-800-442-7247 or 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 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 1-800-442-7247.

*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** **$250**
- **Specialist copayment** **$40**
- **Hospital(facility)copay+coinsurance** **$100+20%**
- **Other (Tests) copayment** **$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	$250
Copayments	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,110**

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

- **The plan's overall deductible** **$250**
- **Specialist copayment** **$40**
- **Hospital(facility)copay+coinsurance** **$100+20%**
- **Other (Brand drugs) copayment** **$30**

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	$250
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
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** **$250**
- **Specialist copayment** **$40**
- **Hospital (ER) copayment** **$100**
- **Other (Physical Therapy) copayment** **$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	$250
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$750**

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