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 1-877-867-7602. 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.specializedcarecoordinators.com or call 1-888-970-7977 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	Per participant:	$0	See the Common Medical Events chart below for your costs for services this plan covers.
	Per family:	$0	
Are there services covered before you meet your deductible?	Yes. Preventive Care and services that require a co-payment. This Plan does not have a 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?		Network	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.
	Per participant:	$3,500	
	Per family:	$7,000	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, 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, for medical. See www.anthem.com or call 1-877-867-7602 for a list of network providers. Yes, for prescription drugs. See www.caremark.com for a list of retail and mail order pharmacies or call 1-866-475-0056.		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 co-payment per service/day	Not Covered	The co-payment applies to the office visit only. All other services rendered during the physician's office visit are paid at the applicable level.
	Specialist visit	$30 co-payment per service/day	Not Covered	——————————none——————————
	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 you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	——————————none——————————
	Imaging (CT/PET scans, MRIs)	Physician's Office: $100 co-payment/ test Freestanding Radiology Center: $100 co-payment/ test Outpatient Hospital: 20% co-insurance	Not Covered	Pre-certification is required.

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.caremark.com	Generic drugs (Tier 1)	Retail (30-day supply) $10 co-payment per prescription Mail Order (90 day supply) $20 co-payment per prescription	Retail (30-day supply) $10 co-payment per prescription	Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.caremark.com If you obtain prescription drugs from a non-network pharmacy, you will be required to pay the full cost of the prescription and then submit for reimbursement. Specialty drugs must be purchased from CVS Specialty, the specialty drug vendor.
	Preferred brand drugs (Tier 2)	Retail (30-day supply) $25 co-payment per prescription Mail Order (90 day supply) $50 co-payment per prescription	Retail (30-day supply) $25 co-payment per prescription	
	Non-preferred brand drugs (Tier 3)	Retail (30-day supply) $45 co-payment per prescription Mail Order (90 day supply) $90 co-payment per prescription	Retail (30-day supply) $45 co-payment per prescription	
	Specialty drugs (Tier 4)	20% co-insurance - up to $150 maximum co-payment per prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance per service/day	Not Covered	Pre-certification is required.
	Physician/surgeon fees	No charge	Not Covered	——————————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 immediate medical attention	Emergency room care	$200 co-payment/visit	$200 co-payment/visit	Co-payment waived if admitted.
	Emergency medical transportation	$100 co-payment per trip		Charted flights are Not Covered.
	Urgent care	$20 co-payment per service/day	Not Covered	The co-payment applies to the office visit only. All other services rendered during the physician's office visit are paid at the applicable level.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	Not Covered	Pre-certification is required. If pre-certification is not received on non-network services, a $500 penalty may apply.
	Physician/surgeon fees	No charge	Not Covered	——————————none——————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $20 co-payment All other services: 20% co-insurance	Not Covered	——————————none——————————
	Inpatient services	20% co-insurance	Not Covered	Pre-certification is required. If pre-certification is not received on non-network services, a $500 penalty may apply.
If you are pregnant	Office visits	$20 co-payment per service/day	Not Covered	Depending on the type of services, a co-payment, co-insurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% co-insurance	Not Covered	
	Childbirth/delivery facility services	20% co-insurance	Not Covered	

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 help recovering or have other special health needs	Home health care	$20 co-payment /day	Not Covered	Pre-certification is required. Annual Maximum: One-hundred (100) days.
	Rehabilitation services	Provider's Office: $20 co-payment per service/day Other outpatient facility: 20% co-insurance	Not Covered	Pre-certification is required. Annual Maximum: Twenty-four (24) visits, Physical Therapy, Occupational Therapy and Chiropractic Care combined.
	Habilitation services	Provider's Office: $20 co-payment per service/day Other outpatient facility: 20% co-insurance	Not Covered	
	Skilled nursing care	$20 co-payment /day	Not Covered	Pre-certification is required. If pre-certification is not received on non-network services, a $500 penalty may apply.
	Durable medical equipment	20% co-insurance	Not Covered	Pre-certification is required for purchases over $500 and all rentals.
	Hospice services	No charge	Not Covered	Pre-certification is required.
If your child needs dental or eye care	Children's eye exam	Not Covered		——————————none——————————
	Children's glasses	Not Covered		
	Children's dental check-up	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 (Adult)
- Hearing aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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 (limited to 20 visits)
- Bariatric surgery
- Chiropractic care (limited to 24 visits per year combined with Physical and Occupational Therapy)
- Infertility treatment ($10,000 lifetime maximum)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Plan's COBRA Administrator at NAVIA, P.O. Box 70366, Bellevue, WA 98007, 1-877-920-9675. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
You may also contact the Care Coordinators to assist the plan administrator with claims adjudication. The Care Coordinators name, address, and telephone number are:

Quantum Health Care Coordinators
7450 Huntington Park Drive, Suite 100
Columbus, OH 43235
1-888-970-7977

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 1-888-970-7977.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-970-7977.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-888-970-7977.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-970-7977.

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 co-payment	$30
Hospital (facility) cost sharing	20%
Other cost sharing	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	$0
Copayments	$100
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$2,410

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 co-payment	$30
Hospital (facility) cost sharing	20%
Other cost sharing	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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,210

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

The plan's overall deductible	$0
Specialist co-payment	$30
Hospital (facility) cost sharing	20%
Other cost sharing	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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$450
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$520

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