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, go to login.personifyhealth.com or call Personify Health at 1-855-511-1530. 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 1-866-444-EBSA (3272) to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	Network $1,000/individual, $2,000/family	Out-of-Network $3,000/individual, $6,000/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.
	Network and non-network deductibles are separate.		
Are there services covered before you meet your deductible?	Yes, network preventive services, services paid with a copayment, and services paid at no charge.		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 $6,000/individual, $12,000/family	Out-of-Network $12,000/individual, $24,000/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.
	Network and Non-Network out-of-pocket limits are separate.		
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, failure to obtain 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 1-800-676-2583 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.

* For more information about limitations and exceptions, see the plan or policy document at login.personifyhealth.com.

Important Questions	Answers	Why This Matters:
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
		Anthem 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	$20/visit, Deductible Waived	40% coinsurance after deductible	None
	Specialist visit	$20/visit, Deductible Waived	40% coinsurance after deductible	
	Preventive care/screening/ immunization	No Charge, Deductible Waived	40% coinsurance after deductible	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization may be required for certain services. If preauthorization is not obtained, you will be responsible for all billed charges related to the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Anthem Provider (You will pay the least)	Out-of-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.truerx.com	Generic drugs (Tier 1)	**Retail (1-30 day supply)** $10/prescription **Retail (31-90 day supply)** $30/prescription **Mail Order** $20/prescription	Not covered. Purchases at a non-participating pharmacy require you to pay in full then submit a claim form for reimbursement.	Retail & Mail Order are limited to a 90-day supply. Specialty drugs are limited to a 30-day supply. Deductible does not apply for prescription drugs.
	Preferred brand drugs (Tier 2)	**Retail (1-30 day supply)** $35/prescription **Retail (31-90 day supply)** $105/prescription **Mail Order** $105/prescription		
	Non-preferred brand drugs (Tier 3)	**Retail (1-30 day supply)** $70/prescription **Retail (31-90 day supply)** $210/prescription **Mail Order** $210/prescription		
	Specialty drugs (Tier 4)	25% up to $250 max, or the max of any available manufacturer-funded copay assistance.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization may be required for certain services. If preauthorization is not obtained, you will be responsible for all billed charges related to the service.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Anthem Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	**Office** $20/visit, Deductible Waived **Other** 20% coinsurance after deductible	40% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$200/visit, then 20% coinsurance, Deductible Waived		Copayment waived if admitted to hospital.
	Emergency medical transportation	20% coinsurance after deductible		None
	Urgent care	$75/visit, Deductible Waived	40% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required. If preauthorization is not obtained, you will be responsible for all billed charges related to the service.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office** $20/visit, Deductible Waived **Other** 20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization may be required for facility services. If preauthorization is not obtained, you will be responsible for all billed charges related to the service.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required. If preauthorization is not obtained, you will be responsible for all billed charges related to the service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Anthem Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$20/visit, Deductible Waived	40% coinsurance after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance/copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is only required for stay exceeding 48 hours after delivery (or 96 hours after C-section). If preauthorization is not obtained, you will be responsible for all billed charges related to the service.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 100 visits per Calendar Year. Preauthorization is required. If preauthorization is not obtained, you will be responsible for all billed charges related to the service.
	Rehabilitation services	**Office** $20/visit, Deductible Waived **Other** 20% coinsurance after deductible	40% coinsurance after deductible	Physical, Occupational, and Speech therapies are limited to a combined 60 visits per Calendar Year. Limits do not apply to ABA therapy.
	Habilitation services	**Office** $20/visit, Deductible Waived **Other** 20% coinsurance after deductible	40% coinsurance after deductible	

* For more information about limitations and exceptions, see the plan or policy document at login.personifyhealth.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Anthem Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 90 days per Calendar Year. Preauthorization is required. If preauthorization is not obtained, you will be responsible for all billed charges related to the service.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization may be required for certain services/equipment. If preauthorization is not obtained, you will be responsible for all billed charges related to the service.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required. If preauthorization is not obtained, you will be responsible for all billed charges related to the service.
If your child needs dental or eye care	Children's eye exam	No charge, Deductible Waived	40% coinsurance after deductible	None
	Children's glasses	Not covered	Not covered	Must enroll in separate vision plan.
	Children's dental check-up	Not covered	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult) / (Child)
- Long-term care
- Non- emergency care when traveling outside the U.S.
- 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.)

- Bariatric surgery
- Chiropractic care (limited to 20 visits per Calendar Year)
- Hearing Aids (limited to 1 hearing aid for each hearing-impaired ear every 36 months for dependent children under age 18)
- Infertility Treatment (20,000 lifetime maximum/ medical & pharmacy combined)
- Private-duty nursing (limited to 82 days per Calendar Year)
- Routine Eye Exam (Adult) / (Child)

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: Personify Health at 1-855-511-1530 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 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: Personify Health at 1-855-511-1530 and 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 1-855-511-1530

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at login.personifyhealth.com.

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** **$1,000**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **20%**
- **Other (tests) copayment** **$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	$1,000
Copayments	$10
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,170**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **20%**
- **Other (brand name drugs) copayment** **$35**

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	$800
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

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

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$20**
- **Hospital (ER) copayment** **$200**
- **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	$1,000
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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