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 770-997-9910 or toll-free at 800-241-2136. 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:/healthcare.gov/sbc-glossary or call 770-997-9910 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network providers: $1,000/individual; $2,000/family. Non-Network providers: $2,000/individual; $4,000/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. Preventive services, network provider office visits, prescription drugs, emergency room care, preventive dental services and vision services are covered before you meet your 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?	Yes. Dental services - $100/individual. There are no other specific deductibles	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network providers: $7,000/individual; $14,000/family. Non-Network providers: $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.
What is not included in the out-of-pocket limit?	Premiums, balance billing, penalties for failure to obtain preauthorization, dental or vision services (except those covered under major medical), 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, Blue Card PPO. See www.anthem.com or call 1-833-664-2851 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.

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
		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	$35 copay/visit. Deductible does not apply.	50% coinsurance	No charge for visits completed through LiveHealth Online (www.livehealthonline.com) $15 copay/visit for visits completed at a retail health clinic
	Specialist visit	$35 copay/visit then 30% coinsurance. Deductible does not apply.	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge. Deductible does not apply.	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.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	Preauthorization is required for genetic testing and Imaging. No coverage if you fail to obtain preauthorization. Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	Retail: Greater of $10 copay/script or 10% coinsurance, not to exceed $20 Home Delivery: Greater of $25 copay/script or 10% coinsurance, not to exceed $40	Not covered	Deductible does not apply. Coverage is limited to 30-day supply for non-maintenance and specialty drugs. Coverage is limited to 90-day supply for maintenance drugs. Copays for 90-day supply at retail are 3 times the 30-day supply amounts shown. Coverage for Home Delivery is limited to maintenance medications only. If brand name drug is requested when there is an equivalent generic alternative, you will be
	Preferred brand drugs	Retail: Greater of $20 copay/script or 20% coinsurance, not to exceed $50	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)	
		Home Delivery: Greater of $50 copay/script or 20% coinsurance, not to exceed $100		required to pay the difference in cost between the brand name and generic. Coverage for certain medications may be subject to step therapy, preauthorization or other utilization management programs. Failure to obtain preauthorization will result in the drug not being covered. Specialty drugs must be obtained through the Optum Specialty Pharmacy.
	Non-preferred brand drugs	Retail: Greater of $35 copay/script or 30% coinsurance, not to exceed $75 Home Delivery: Greater of $75 copay/script or 30% coinsurance, not to exceed $150	Not covered	
	Biosimilar Specialty drugs	Lesser of $100 copay/ script or 8% coinsurance	Not covered	
	Preferred Specialty drugs	Lesser of $250 copay/ script or 15% coinsurance	Not covered	
	Non-Preferred Specialty drugs	Lesser of $400 copay/ script or 25% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance (20% coinsurance if use BDC or BDC+ facility for certain services)	Not covered for bariatric, cardiac, certain orthopedic or transplant surgeries. 50% coinsurance for other surgeries.	Preauthorization is required. If you don't get preauthorization, all charges may be denied. To pay 10% coinsurance on facility fees for bariatric, cardiac, knee replacement, hip replacement, spine or transplant surgeries, a hospital designated as a Blue Distinction Center or Blue Distinction Center + (BDC or BDC+) must be used. Facility fees are not covered if these surgeries are performed at a non-network provider. Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Physician/surgeon fees	30% coinsurance	50% 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 immediate medical attention	Emergency room care	$300 copay/visit then 30% coinsurance. Deductible does not apply.	Covered as In-Network	Copay is waived if admitted to the hospital.
	Emergency medical transportation	30% coinsurance	Covered as In-Network	None
	Urgent care	$75 copay/visit. Deductible does not apply.	50% coinsurance	Emergency services provided at a non-network Urgent Care center licensed to operate as a freestanding emergency department may be covered as in-network
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance (20% coinsurance if use BDC or BDC+ facility for certain services)	Not covered for bariatric, cardiac, certain orthopedic or transplant surgeries. 50% coinsurance for other surgeries.	Preauthorization is required. If you don't get preauthorization, all charges may be denied. To pay 10% coinsurance on facility fees for bariatric, cardiac, knee replacement, hip replacement, spine or transplant surgeries, a hospital designated as a Blue Distinction Center or Blue Distinction Center + (BDC or BDC+) must be used. Facility fees are not covered if these surgeries are performed at a non-network provider. Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/office visit. Deductible does not apply. 30% coinsurance/ other outpatient services	50% coinsurance	No charge for visits completed through LiveHealth Online (www.livehealthonline.com). Preauthorization is required for certain other outpatient services. If you don't get preauthorization, all charges may be denied.
	Inpatient services	30% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, all charges may be denied.
If you are pregnant	Office visits	$35 copay/office visit. Deductible does not apply.	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance and deductible may

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)	
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	apply to office visits. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Certain services received from non-network providers while at an in-network facility will be covered as in-network.
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, all charges may be denied.
	Rehabilitation services	30% coinsurance	50% coinsurance	None
	Habilitation services	30% coinsurance	50% coinsurance	None
	Skilled nursing care	30% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, all charges may be denied.
	Durable medical equipment	30% coinsurance	50% coinsurance	Preauthorization is required. If you don't get preauthorization, all charges may be denied.
	Hospice services	30% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	$10 copay/visit. Deductible does not apply.	All charges in excess of $50. Deductible does not apply.	Limited to one exam/year. Not included in out-of-pocket limit.
	Children's glasses	$15 copay for lenses. Deductible does not apply.	All charges in excess of $50-$125 (depending on lens type); $70 (frames). Deductible does not apply.	Limited to 1 set of lenses/year and 1 pair of frames every 2 years. Additional charges will apply for frames purchased from a network provider over $140 retail value or special coatings/tints to lenses. Not included in out-of-pocket limit.
	Children's dental check-up	No Charge. Deductible does not apply.	All charges over UCR. Deductible does not apply.	Limited to one exams/six months and $2,000 annual maximum. Not included in out-of-pocket limit.

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, except to repair disfigurement caused by an accident, abnormal congenital conditions of a child or where required by law
- Hearing Aids
- Long-term 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
- Bariatric surgery, if pre-certified and determined to be medically necessary
- Chiropractic care, limited to 12 visits/year
- Dental care (adult), limited to $2,000 annual maximum
- Infertility treatment, except for artificial insemination or assisted reproductive technology procedures
- Non-emergency care when traveling outside the U.S. (visit www.anthem.com)
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

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: 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: the Plan at 1-800-241-2136 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 1-800-241-2136.

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	$550
Specialist copayment	$35 + 30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$3,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,570**

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

The plan's overall deductible	$550
Specialist copayment	$35 + 30%
Hospital (facility) coinsurance	30%
Other coinsurance	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	$0
Copayments	$800
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,600**

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

The plan's overall deductible	$550
Specialist copayment	$35 + 30%
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

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