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 1-877-208-5952. 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 1-877-208-5952 to request a copy. For assistance with claims and medical benefits contact **Empire Health Valenz Navcare Concierge Services at 1-877-208-5952. For Preauthorization or for Case Management contact Healthlink at 1-877-284-0102.**

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: $2,500 individual / $5,000 family Out-of-network providers: $5,000 individual / $10,000 family **Benefit Period: Calendar Year**	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 (Embedded).
Are there services covered before you meet your deductible?	**Yes**. Prescription drugs, Preventive care, Emergency Room/Urgent care, primary / specialist office visits, pre/post-natal care, Outpatient mental health/ substance abuse services, inpatient mental health/substance abuse services for (Centers of Excellence) Bella Monte & Core Centers providers, routine eye exam and rehabilitation 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network providers: $5,000 individual / $10,000 family Out-of-network providers: $10,000 individual / $20,000 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 (Embedded).
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for 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. This plan uses the **Blue Cross Blue Shield PPO Network**. A list of network providers can be found at www.anthem.com or call 1-800-810-2583.	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 a 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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Professional Non-Facility based services:** $45 copay/per visit **Facility based services:** $45 copay/per visit *Savings Plus Plan Benefit*	50% coinsurance after deductible	Copay applies per visit regardless of what services are rendered. Telemedicine via 1800MD at 1-800-591-2076 or www.thehealthwallet.com
	Specialist visit to treat an injury or illness	**Professional Non-Facility based services:** $65 copay/per visit **Facility based services:** $65 copay/per visit *Savings Plus Plan Benefit*	50% coinsurance after deductible	
	Preventive care/screening/ immunization	No charge	50% coinsurance after deductible	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)	**Lab, Pathology & Radiology: Office Setting:** $75 copay/per visit **Lab, Pathology & Radiology: Independent Lab & Facility Based Services:** $75 copay/per visit *Savings Plus Plan Benefit*	50% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance after deductible *Savings Plus Plan Benefit*	50% coinsurance after deductible	Preauthorization is required for PET/CAT/MRI/MRA. Preauthorization is required and is mandatory. Failure to preauthorize shall result in claim denial.

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)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about Tier 1, 2, and 3 prescription drug coverage is available at www.carelonrx.com or call **1-833-271-2374**	Generic drugs (Tier 1)	$15 copay Retail $30 copay Mail Order	$15 copay, then 25% coinsurance (Retail)	**Deductible does not apply.** Dispense as Written (DAW) provision does apply. Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). No cost for ACA preventive care drugs. Specialty drugs will be administered by Payer Matrix. Please contact Payer Matrix at 1-877-305-6202 or visit www.payermatrix.com .Mandatory mail order and mail order pharmacy are required to be filled through United/Xcel-Rx at 1-877-888-7282 or visit www.unitedxcelrx.com. Preauthorization is required for injectables over $2,000 per drug per month. Preauthorization is required and is mandatory. Failure to preauthorize shall result in claim denial.
	Preferred brand drugs (Tier 2)	$50 copay Retail $70 copay Mail Order	$50 copay, then 25% coinsurance (Retail)	
	Non-preferred brand drugs (Tier 3)	$85 copay Retail $140 copay Mail Order	$85 copay, then 25% coinsurance (Retail)	
	Specialty drugs (Tier 4)	Contact Payer Matrix for assistance at 1-877-305-6202	Contact Payer Matrix for assistance at 1-877-305-6202	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible *Savings Plus Plan Benefit*	50% coinsurance after deductible	Preauthorization is required for certain services and surgeries, including infusion therapy costing over $2,000 per drug per month. Preauthorization is required and is mandatory. Failure to preauthorize shall result in claim denial.
	Physician/surgeon fees	20% coinsurance after deductible *Savings Plus Plan Benefit*	50% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$400 copay/per visit *Savings Plus Plan Benefit*		ER copay is waived if admitted as inpatient. All facilities are covered as in-network subject to meeting “emergency” criteria. Non-participating providers paid at the participating provider level of benefits.

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)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	25% coinsurance after deductible *Savings Plus Plan Benefit*		All facilities are covered as in-network subject to meeting "emergency" criteria. Non-participating providers paid at the participating provider level of benefits.
	Urgent care	$25 copay/per visit	50% coinsurance after deductible	Copay applies per visit regardless of what services are rendered. Telemedicine via 1800MD at 1-800-591-2076 or www.thehealthwallet.com
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/per admission, then 20% coinsurance after deductible *Savings Plus Plan Benefit*	50% coinsurance after deductible	Preauthorization is required and is mandatory. Failure to preauthorize shall result in claim denial. To speak with a Case Manager, contact Healthlink Case Management Services at 1-877-284-0102
	Physician/surgeon fees	20% coinsurance after deductible *Savings Plus Plan Benefit*	50% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Professional Non-Facility based services:** $45 copay/per visit **Facility based services:** $45 copay/per visit *Savings Plus Plan Benefit*	50% coinsurance after deductible	Mental/Behavioral Health or Substance Abuse Telemedicine via 1800MD at 1-800-591-2076 or www.thehealthwallet.com
	Inpatient services	(**Centers of Excellence)** Bella Monte and Core Centers providers $1000 copay/per admission (facility charges)/No Charge (professional fees) **All other Providers**: $200 copay/per admission, then 20% coinsurance after deductible *Savings Plus Plan Benefit*	50% coinsurance after deductible	Preauthorization is required and is mandatory. Failure to preauthorize shall result in claim denial. To speak with a Case Manager, contact Healthlink Case Management Services at 1-877-284-0102
If you are pregnant	Office visits	**Professional Non-Facility**	50% coinsurance after	Cost sharing does not apply to certain

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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		based services: No Charge after initial $45 copay **Facility based services:** No Charge after initial $45 copay *Savings Plus Plan Benefit*	deductible	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). Preauthorization is required for inpatient stay over 48 hours for a vaginal delivery or 96 hours for a cesarean section. Preauthorization is required and is mandatory. Failure to preauthorize shall result in claim denial. Newborn does not count toward the mother's expense; therefore the family deductible may apply.
	Childbirth/delivery professional services	20% coinsurance after deductible *Savings Plus Plan Benefit*	50% coinsurance after deductible	
	Childbirth/delivery facility services	$200 copay / per admission then 20% coinsurance after deductible *Savings Plus Plan Benefit*	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	Maximum 60 visits per calendar year. Preauthorization is required and is mandatory. Failure to preauthorize shall result in claim denial. To speak with a Case Manager, contact Healthlink Case Management Services at 1-877-284-0102
	Rehabilitation services	$65 copay/per visit *Savings Plus Plan Benefit*	50% coinsurance after deductible	Maximum 60 visits per calendar year per therapy (Physical therapy, speech therapy, and occupational therapy) Preauthorization is required and is mandatory. Failure to preauthorize shall result in claim denial.
	Habilitation services	$65 copay/per visit *Savings Plus Plan Benefit*	50% coinsurance after deductible	
	Skilled nursing care	20% coinsurance after deductible *Savings Plus Plan Benefit*	50% coinsurance after deductible	Maximum 60 visits per calendar year. Preauthorization is required and is mandatory. Failure to preauthorize shall result in claim denial.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization is required items including electric/motorized scooters, wheelchairs, and pneumatic compression

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)	Out-of-Network Provider (You will pay the most)	
				devices. Preauthorization is required and is mandatory. Failure to preauthorize shall result in claim denial.
	Hospice services	20% coinsurance after deductible	50% coinsurance after deductible	Bereavement counseling is covered if received within 6 months of death. Preauthorization is required and is mandatory. Failure to preauthorize shall result in claim denial.
If your child needs dental or eye care	Children's eye exam	No Charge	50% coinsurance after deductible	Coverage limited to one exam every 24 months
	Children's glasses	Not Covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not Covered Except for ACA mandated services	Not covered	Dental caries fluoride application for infants and children up to 5 years are covered as preventive services. Cost sharing does not apply for preventive services.

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 (excluding anesthetic usage)
- Bariatric Surgery
- Cosmetic Surgery
- Genetic Testing
- Glasses (Adult & Child)
- Hearing aids
- Infertility treatment (except diagnosis)
- Long-term care
- Maternity care for dependent daughters
- Non-Emergency use of Emergency services
- Non-Emergency care when traveling outside the U.S.
- Routine Dental Care (Adult & Child)
- Routine Foot Care (except for metabolic or peripheral vascular disease)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care (limited to 25 visits per calendar year)
- Dental Care Non-Routine Services & Injury
- Private-duty nursing

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. For more information on your rights to continue coverage, contact the plan at 1-877-208-5952.

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: 1-877-208-5952.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual mark 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 1-877-208-5952
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-208-5952
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-208-5952
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-208-5952

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** **$2,500**
- **Specialist copayment** **$65**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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	**$12,687**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$994
Coinsurance	$1,192
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$4,747**

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

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$65**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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	**$5,601**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$790
Copayments	$1,840
Coinsurance	$0
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$2,652**

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

- **The plan's overall deductible** **$2,500**
- **Specialist copayment** **$65**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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*	$1,235
Copayments	$930
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,165**

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