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, 1-866-259-5540. 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.webtpa.com or call 1-800-259-5540 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $0/Individual or $0/Family For out-of-network providers $0/Individual or $0/Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Because there is no deductible, deductible does not apply.
Are there services covered before you meet your deductible?	Yes. Preventive services for network providers 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.	There are no other specific deductibles.
What is the out-of-pocket limit for this plan?	For network providers $3,000 Individual / $6,000 Family; For out-of-network providers No limit Individual / No limit Family. Prescription in-network $2,500 Individual/ $3,500 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, all billed amounts exceeding the maximum allowed amount 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 1-866-259-5540 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).
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)	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	$0 Copay	All billed amounts exceeding the maximum allowed amount	None
	Specialist visit	$100 Copay	All billed amounts exceeding the maximum allowed amount	Copay applies to the office visit. Additional testing / diagnostic / surgical services are subject to the applicable copay for those services.
	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)	Office Lab: $0 Copay Freestanding Lab: $0 Copay Outpatient Hospital Lab: $150 Copay Office X-Ray: $0 Copay PCP $75 Copay Specialist Freestanding X:Ray: $75 Copay Outpatient Hospital X-Ray: $225 Copay	Not Covered	None

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

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)	
	Imaging (CT/PET scans, MRIs)	Freestanding Radiology Center: $300 Copay Outpatient Hospital: $750 Copay	All billed amounts exceeding the maximum allowed amount	Out-of-network providers are limited to $800 maximum per test for imaging.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com	Generic drugs	Retail: $9 Costco: Free Mail Order: Free	Not Covered	Retail – 30 Day Supply Costco – 30 Day Supply Mail Order (Costco Mail only) – 90 Day Supply. Three 30 day fills are required before a 90 day fill is allowed. Specialty Drugs only available for 30 day supply from a designated mail order specialty pharmacy. Costco can supply 30, 60, and 90 Days at Costco pharmacies and Costco Mail Order only. For non-preferred brand drugs it is $35, $70, and $90 respectively. Three 30 Day fills are require at all pharmacies before a 90 day fill is allowed. "Preferred" indicates the drug is included on the Preferred Drug List and is prescribed by a PCP or a Value Added Provider.
	Preferred brand drugs	Retail: Free Costco: Free Mail Order: Free	Not Covered	
	Non-preferred brand drugs	Retail: $35 Costco: $35 Mail Order: $90	Not Covered	
	Specialty drugs	Preferred: Free Non-Preferred: $35	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $600 Copay Hospital: $1,800 Copay	All billed amounts exceeding the maximum allowed amount	
	Physician/surgeon fees	Included in above copays	All billed amounts exceeding the maximum allowed amount	
If you need immediate medical attention	Emergency room care	$700 Copay	Covered as In-Network	Your ER Copay will be waived if admitted. Inpatient Hospital Copay(s) apply if admitted.

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

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	$700 Copay (ground or air)	Covered as In-Network	Additional testing, diagnostic, surgical services are subject to the applicable Copay for those services. Authorized out-of-network non-emergency ambulance services are limited to a maximum payment of $50,000 per trip.
	Urgent care	$0 Copay	Covered as In-Network	
If you have a hospital stay	Facility fee (e.g., hospital room)	$600 Copay per day	All billed amounts exceeding the maximum allowed amount	Hip/Knee/Spine inpatient procedures required at a Blue Distinction Center. Coverage for non-emergency inpatient admissions to out-of-network providers is limited to $600 maximum per day.
	Physician/surgeon fees	Included in the $600 per day Copay	All billed amounts exceeding the maximum allowed amount	Coverage for non-emergency inpatient admissions to out-of-network providers is limited to $600 maximum per day.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 Copay	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount	Prior auth required for Facility services. Physician fees are included in the per day Facility fee.
	Inpatient services	$0 Copay	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount	
If you are pregnant	Office visits	$0 Copay	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount	Cost sharing does not apply to certain preventive services. Depending on the type of services, a Copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Included in the $600 facility Copay per day.	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount	
	Childbirth/delivery facility services	$600 Copay per day	All billed amounts exceeding the lesser of the	

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

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)	
			benefit maximum or maximum allowed amount	
If you need help recovering or have other special health needs	Home health care	$0 Copay	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount	Limited to 100 visits per calendar year. Coverage for out-of-network providers is limited to $150 maximum per day.
	Rehabilitation services	$0 Copay	Not covered	Limited to 36 office and outpatient visits per calendar year.
	Habilitation services	$0 Copay	Not covered	
	Skilled nursing care	$1,200 Copay per admission	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount	Limited to 150 days per calendar year.
	Durable medical equipment	$0 Copay	Not covered	Pre-certification required for DME in excess of $1,000 purchase / rental price.
	Hospice services	$0 Copay	All billed amounts exceeding the lesser of the benefit maximum or maximum allowed amount	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)

- Dental Care (Adult)
- Private-duty Nursing
- Non-emergency care when traveling outside the U.S.
- Infertility Treatment
- Routine Eye Care (Adult)
- Cosmetic Surgery
- Long-Term Care
- 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
- Hearing Aids
- Bariatric Surgery
- Chiropractic 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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov . Other

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

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: 1-866-259-5540

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 1-800-259-5540.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-259-5540.
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-800-259-5540.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-259-5540.

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 [www.insert.com].]

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* For more information about limitations and exceptions, see the plan or policy document at [www.insert.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	**$0**
Specialist copayment	**$100**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**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	**$12,040**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$660**

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 copayment	**$100**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	**$5,280**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$320**

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

The plan's overall deductible	**$0**
Specialist copayment	**$100**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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	**$1,300**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$1,500
Coinsurance	$0
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.