

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, contact Sage TPA at 1-855-959-5956. 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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Provider: $0 Per Plan Participant $0 Per Family Unit Non-Network $1,000 Per Plan Participant $3,000 Per Family Unit	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. PPO Preventive care	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 Provider: $7,500 Per Plan Participant $15,000 Per Family Unit Non-Network Unlimited Per Plan Participant Unlimited Per Family Unit	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, Pre-service review penalties, balance-billing charges (unless balance-billing is prohibited), and health care this plan doesn't cover.	Yes OOP limit applies: Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. For a list of providers, see Anthem.com or call 1-855-929-5956	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.

* For more information about limitations and exceptions, contact Sage TPA at 1-855-959-5956.

Common Medical Event	Services You May Need	PPO Provider (You will pay the least)	Non-PPO 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	$25 copay	$25 copay then 25% coinsurance after deductible	The office visit copayment applies once per visit and includes the exam and supplies when performed on the same day, by the same provider, and regardless of an office visit charge. Deductible and coinsurance applies to PPO office surgery and allergy testing/serum/injections.
	Specialist visit	$25 copay	$25 copay then 25% coinsurance after deductible	
	Preventive care/screening/ immunization	No Charge	25% 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)	No Charge	25% coinsurance after deductible	
	Imaging (CT/PET scans, MRIs)	$25 copay	$25 copay then 25% coinsurance after deductible	
If you need drugs to treat your illness or condition	Generic drugs 30 day supply/ 90 day supply & Mail order	$5 copay / $10 copay	N/A	Deductible does not apply to prescription drug coverage. One copayment per 30-day supply, up to a 90-day supply. Standard Formulary applies. Certain Women's Preventative Services will be covered with no cost to the member.
	Preferred brand drugs	$35 copay / $70 copay	N/A	
	Non-preferred brand drugs	$60 copay / $120 copay	N/A	
	Specialty drugs	$5 copay / $35 copay / $60 copay	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copay	$85 copay then 25% after deductible	"Outpatient Surgery/Surgical Procedures - precertification required only for the following: Nasal, Bariatric, Abdominoplasty. Lipectomy, Panniculectomy and Breast surgeries or cosmetic."
	Physician/surgeon fees	$50 copay	$85 copay then 25% after deductible	
If you need immediate medical attention	Emergency room care	$100 copay	$100 copay	
	Emergency medical transportation	$70 copay	$70 copay	
	Urgent care	$35 copay	$45 copay then 25% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay per admission	$500 copay per admission then 25% coinsurance after deductible	Pre-Certification Required.
	Physician/surgeon fees	$25 copay	$25 copay the 25% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services (Facility and Physician)	$100 copay	$25 copay then 25% coninsurance after $500 deductible per treatment	Pre-Certification Required.
	Office Visits (includes outpatient therapy)	$25 copay per visit	$25 copay then 25% coninsurance after $500 deductible per treatment	The office visit copayment applies once per visit and includes the exam and supplies when performed on the same day, by the same provider, and regardless of an office visit charge.
	Inpatient services	$100 copay	$25 copay then 25% coninsurance after $500 deductible per treatment	Pre-Certification Required.

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If you are pregnant	Office visits	$25 copay	$25 copay then 25% coinsurance after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	$25 copay	25% coinsurance after deductible	
	Childbirth/delivery facility services	$100 copay per admission	$500 copay per admission	
If you need help recovering or have other special health needs	Home health care	No charge	25% coinsurance after deductible	Pre-Certification required.
	Rehabilitation services	$10 copay Cardiac Therapy,$25 copay Autism Spectrum Disorder Treatment, Chemotherapy/Radiation Therapy 100% covered.	$25/$85 copay then 25% after deductible - Cardiac Therapy,$25 copay then 25% coinsurance after deductible - Autism Spectrum Disorder Treatment, $25/$85 copay then 25% coinsurance after deductible - Chemotherapy/Radiation Therapy.	Autism Spectrum Disorder Treatment- limted to $45,000 annually
	Habilitation services	See Rehabilitation Services above.		
	Skilled nursing care	$100 copay per admission	$500 copay per admission then 25% coinsurance after deductible	Pre-Certification Required. Limited to 180 days per Plan Year.
	Durable medical equipment	$25 copay	$25 copay the 25% coinsurance after deductible	Pre-Certification required for DME over $1,500 excluding CPAP, insulin pumps and hearing aids. Inspire is not covered.
	Hospice services	No charge	No charge, deductible waived	Hospice Care is available if Your primary attending Physician has certified that You have 12 months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies.
If your child needs dental or eye care	Children's eye exam	Not Covered		None
	Children's glasses	Not Covered		None
	Children's dental check-up	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Infertility Treatment
- Long-Term Care
- Routine foot Care
- Private-Duty Nursing
- 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
- Hearing Aids

* For more information about limitations and exceptions, contact Sage TPA at 1-855-959-5956.

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: For group health coverage subject to ERISA, contact 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: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may help with your appeal. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthcarereform and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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**

f 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 (855)-929-5956

Footer: * For more information about limitations and exceptions, contact Sage TPA at 1-855-959-5956.