

 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 1-844-426-9443. 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](http://www.healthcare.gov/sbc-glossary) or call 1-844-426-9443 to request a copy. **For assistance with claims and medical benefits contact LEA Member Services Concierge at 1-844-426-9443.**

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network providers</a> : \$1,000 Individual / \$2,000 Family <a href="#">Out-of-network providers</a> : \$3,000 Individual / \$6,000 Family <b>Benefit Period: Plan Year</b>	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> (Embedded).
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, <a href="#">Preventive care</a> , prescription drugs, and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network providers</a> : \$6,250 Individual / \$12,500 Family <a href="#">Out-of-network providers</a> : \$12,500 Individual / \$25,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met (Embedded).
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">Preauthorization</a> for services, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. This plan uses the <b>National PPO (BlueCard PPO) Network</b> . A list of <a href="#">network providers</a> can be found at <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-810-2583	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see a <a href="#">specialist</a> you choose without a <a href="#">referral</a>



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
		Preferred Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	<b>Professional Non-Facility based services:</b> \$40 <a href="#">copay</a> / per visit <b>Facility based services:</b> \$40 <a href="#">copay</a> / per visit <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	<a href="#">Specialist</a> visit to treat an injury or illness	<b>Professional Non-Facility based services:</b> \$80 <a href="#">copay</a> / per visit <b>Facility based services:</b> \$80 <a href="#">copay</a> / per visit <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<b>Lab: Office Setting or Independent Lab:</b> 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> <b>Xray: Office Setting or Independent Lab:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
		<b>Lab: Facility based services:</b> 50% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i> <b>Xray: Facility based services:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>		
	Imaging (CT/PET scans, MRIs)	<b>Office Setting or Independent Lab:</b> 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Sleep Studies are covered in the home at Office or Independent Lab Cost Share. <a href="#">Preauthorization</a> is required or benefit will be reduced by 20%.
		<b>Facility based services:</b> 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>		

For more information about limitations and exceptions, call 1-844-426-9443



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
		Preferred Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.carelonrx.com">www.carelonrx.com</a> or call 1-833-267-2133.	Generic drugs (Tier 1)	<b>Retail (30-day supply):</b> \$10 copay/prescription <b>Mail Order (90-day supply):</b> \$25 copay/prescription	<b>Retail (30-day supply):</b> \$10 copay/prescription	<b>No Charge for ACA mandated generic medications.</b> <b>Deductible does not apply.</b> Covers up to a 30-day supply (retail subscription); 31-90-day supply (mail order prescription). If a prescription is filled with a non-generic drug when a generic equivalent exists, member will be responsible for the cost difference between the non-generic drug and the generic equivalent.
	Preferred brand drugs (Tier 2)	<b>Retail (30-day supply):</b> \$35 copay/prescription <b>Mail Order (90-day supply):</b> \$87.50 copay/prescription	<b>Retail (30-day supply):</b> \$35 copay/prescription	
	Non-preferred brand drugs (Tier 3)	<b>Retail (30-day supply):</b> \$60 copay/prescription <b>Mail Order (90-day supply):</b> \$150 copay/prescription	<b>Retail (30-day supply):</b> \$60 copay/prescription	
	<a href="#">Specialty drugs</a> (Tier 4)	Some Specialty Drugs are Excluded: Contact Payer Matrix for assistance at 1-877-305-6202 9am - 8pm EST M-F.		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for services. If <a href="#">Preauthorization</a> required but not obtained benefit will be reduced by \$1000 for inpatient stays and 20% for outpatient.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>		All facilities are covered as in-network subject to meeting "emergency" criteria.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>		All facilities are covered as in-network subject to meeting "emergency" criteria.
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> / per visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required or benefit will be reduced by \$1000 for inpatient stays and 20% for outpatient.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None

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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
		Preferred Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<b>Professional Non-Facility based services:</b> \$40 <a href="#">copay</a> / per visit  <b>Facility based services:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Intensive Outpatient therapy and Partial Hospitalization require <a href="#">Preauthorization</a> or benefit will be reduced by \$1000 for inpatient stays and 20% for outpatient.
	Inpatient services	<b>Facility based services:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you are pregnant	Office visits	<b>Professional Non-Facility based services:</b> \$40 <a href="#">copay</a> / per visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<b>Maternity for Dependent Child is covered.</b> <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <a href="#">Preauthorization</a> is required for stays longer than 48 hours for vaginal birth or 96 hours for cesarean birth if <a href="#">Preauthorization</a> is not obtained benefit will be reduced by \$1000 for inpatient stays and 20% for outpatient.
		<b>Facility based services:</b> \$40 <a href="#">copay</a> / per visit <i>Savings Plus Plan Benefit</i>		
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Maximum <b>60</b> visits per benefit period. <a href="#">Preauthorization</a> is required or benefit will be reduced by 20%.
	<a href="#">Rehabilitation services</a>	<b>Professional Non-Facility based services:</b> \$40 <a href="#">copay</a> / per visit  <b>Facility based services:</b> \$40 <a href="#">copay</a> / per visit <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required or benefit will be reduced by \$1000 for inpatient stays and 20% for outpatient.

For more information about limitations and exceptions, call 1-844-426-9443



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
		Preferred Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Habilitation services</a>	<b>Professional Non-Facility based services:</b> \$40 <a href="#">copay</a> / per visit  <b>Facility based services:</b> \$40 <a href="#">copay</a> / per visit <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required or benefit will be reduced by \$1000 for inpatient stays and 20% for outpatient.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Maximum <b>60</b> days per benefit period. Combined In-Network and Out-of-Network limit. <a href="#">Preauthorization</a> is required or benefit will be reduced by \$1000 for inpatient stays and 20% for outpatient.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for items. If <a href="#">Preauthorization</a> required but not obtained benefit will be reduced by 20%.
	<a href="#">Hospice services</a>	<b>Home Setting:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required or benefit will be reduced by \$1,000.
		<b>Facility Setting:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>		
If your child needs dental or eye care	Children's eye exam	Not Covered Except for ACA mandated services	Not Covered	One vision screening for children 3-5 years is covered as a preventive service. Cost sharing does not apply for preventive services.
	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.

For more information about limitations and exceptions, call 1-844-426-9443

## 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 (not related to Mastectomy) | • Oral Surgery            |
| • Alternative Medicine/homeopathy | • Long-Term Care                               | • Private-Duty Nursing    |
| • Aquatic therapy                 | • Non-Emergency Care outside the U.S.          | • Respite Care            |
| • Bariatric Surgery               | • Non-Emergency Care in the ER Setting         | • Sterilization Reversals |
| • Biofeedback                     |  | • Weight Loss Programs    |

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

- |  |  |   |
|--|--|---|
| • Physical Therapy - Limited to 20 visits per plan year. | • Occupational Therapy - Limited to 20 visits per plan year. | • |
|--|--|---|

**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](http://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](http://www.cciio.cms.gov). For more information on your rights to continue coverage, contact the plan at 1-844-426-9443. 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](http://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: 1-844-426-9443.

**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 1-844-426-9443

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-426-9443

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-426-9443

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-426-9443

*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](#) \$1,000
- [Specialist copayment](#) \$80
- 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*)

<b>Total Example Cost</b>	<b>\$12,687</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$50
Coinsurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,910</b>

**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](#) \$80
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$900
Copayments	\$1,100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,020</b>

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$80
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$1,000
Copayments	\$400
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,600</b>