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 HealthComp at 1-800-442-7247. 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 1-800-442-7247 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Provider **$1,500** person/ **$3,000** 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. See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Network preventive care services, immunizations, office visits, urgent care facility visits and network and out-of-network emergency room visits.	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. Network prescription drugs; **$200** person/ **$400** family. (Deductible is waived for Generic drugs). There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before the plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers **$6,000** person / **$12,000** 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, utilization management program penalties, balance-billing charges, 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 www.healthcomp.com or call 1(800) 442-7247 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.

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	$30 copay/visit	Not covered	None
	Specialist visit	$60 copay/visit	Not covered	None
	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)	20% coinsurance	Not covered	Precertification is required. If you don't get precertification, benefits could be reduced.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs (Tier 1)	Retail: $15 copay/prescription Mail order: $37 copay/prescription	Not covered	Prescription drug Deductible, waived for Generic drugs. ($**200** person/ **$400** family) Copayment applies after the deductible has been met. Retail is limited to a 30 day supply. Retail 90 day supply is available at 3 times retail copay. Mail order is limited to a 90 day supply.
	Preferred brand drugs (Tier 2)	Retail: 20% up to $45 copay/prescription Mail order: 20% up to $112 copay/prescription	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail: 20% up to $75 copay/prescription Mail order: 20% up to $187 copay/prescription	Not covered	
	Specialty drugs (Tier 4)	Retail: 20% up to $200 copay/prescription Mail order: 20% up to $500 copay/prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Precertification is required. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	Not covered	None

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 immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	Per visit copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$100 copay/visit	Not covered	Per visit copay waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Precertification is required. If you don't get precertification, benefits could be reduced.
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician's Office: $30 copay/visit Outpatient Facility: 20% coinsurance	Not covered	Precertification is required. If you don't get precertification, benefits could be reduced.
	Inpatient services	20% coinsurance	Not covered	
If you are pregnant	Office visits	$30 copay/visit	Not covered	Cost sharing does not apply to certain 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).
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Coverage is limited to 40 visits calendar year maximum and 16 hours maximum per day. Precertification is required. If you don't get a precertification, benefits could be reduced.
	Rehabilitation services	Primary: $30 copay/visit Specialist: $60 copay/visit	Not covered	Coverage includes Chiropractic services and is limited to 25 visits calendar year maximum per therapy. Cardiac therapy is limited to 36 visits calendar year maximum. Precertification is required for Speech, Occupational, and Physical therapy, and cardiac rehab. If you don't get precertification, benefits could be reduced.

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)	
	Habilitation services	Primary: $30 copay/visit Specialist: $60 copay/visit	Not covered	Coverage is limited to speech, physical and/or occupational therapy for autism spectrum disorder.
	Skilled nursing care	20% coinsurance	Not covered	Coverage is limited to 60 days calendar year maximum. Precertification is required. If you don't get a precertification, benefits could be reduced.
	Durable medical equipment	20% coinsurance	Not covered	Precertification is required. If you don't get a precertification, benefits could be reduced.
	Hospice services	20% coinsurance	Not covered	Precertification is required. If you don't get a precertification, benefits could be reduced.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Must enroll in separate vision plan for vision benefits.
	Children's glasses	Not covered	Not covered	Must enroll in separate vision plan for vision benefits.
	Children's dental check-up	Not covered	Not covered	Must enroll in separate dental plan for dental benefits.

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
- Dental Care (Adult)
- Dental care (Children)
- Eye care (Children)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- 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.)

- 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 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 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: HealthComp Administrators at 1-800-442-7247 or 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.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-442-7247.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-442-7247
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-800-442-7247.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-442-7247.

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** **$1,500**
- **Specialist copayment** **$60**
- **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$120
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,160**

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$60**
- **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,689
Copayments	$1,410
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$3,527**

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$60**
- **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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$687
Copayments	$300
Coinsurance	$172
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,159**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Human Resources Department.

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