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. 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 your Group Administrator. For general definitions of common terms, see the Glossary at healthcare.gov/sbc-glossary or call (844) 286-6371.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500**/indiv., **$1,500**/family for in-network providers. **$7,500**/indiv., **$15,000**/family for out-of-network providers.	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. Preventive care, Primary Care visit, Specialist visit, and Vision exam for In-Network Providers.	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 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?	**$3,500**/indiv.; **$7,000**/family for in-network providers. **$15,000**/indiv.; **$30,000**/family for out-of-network providers. **$1,500**/indiv.; **$3,000**/family for prescriptions.	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?	Services deemed not medically necessary by Anthem or medical management, premiums, 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, Blue Priority PPO for WI providers; Blue Card PPO for providers outside WI. See anthem.com or call (844) 286-6371 for 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
		In-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	$35/visit deductible does not apply	40% coinsurance	--------none--------
	Specialist visit	$50/visit deductible does not apply	40% coinsurance	--------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 needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	$100/visit deductible does not apply	40% coinsurance	--------none--------
If you need drugs to treat your illness or condition	Tier 1 - Typically Generic	$5 Co-payment for Generic Incentive Drugs $15 Co-payment 34DS $30 Co-payment 35-90DS(Mail Order)	N/A	Specialty Drugs are covered for a 30-day Supply at Direct RX except for limited distribution. If a brand name drug is chosen when a generic substitute is available, the member pays the cost difference between brand name drug & the generic drug, plus the brand drug copay. If the qualified practitioner indicates no substitution, then the member only pays the brand drug copay.
	Tier 2 - Typically Preferred / Brand	$40 Co-payment 34DS $80 Co-payment 35-90DS(Mail Order)	N/A	
	Tier 3 - Typically Non-Preferred / Specialty Drugs	$75 Cop-payment 34DS $150 Co-payment 35-90DS(Mail Order)	N/A	
	Tier 4 - Typically Specialty (brand and generic)	5% Max $100(Mail Order)	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	--------none--------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	$350/visit then 20% coinsurance	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	Covered as In-Network	--------none--------
	Urgent care	$50/visit	$50/visit	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $25/visit deductible does not apply Other Outpatient 20% coinsurance	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	20% coinsurance	40% coinsurance	--------none--------
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	40 visits/benefit period including private duty nursing.
	Rehabilitation services	20% coinsurance	40% coinsurance	*See Therapy Services section
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	30 days limit/benefit period. Member must be admitted to SNF within 24 hours of discharge from an inpatient facility and treatment must be for the same condition.
	Durable medical equipment	20% coinsurance	40% coinsurance	*See Durable Medical Equipment Section
	Hospice services	20% coinsurance	40% coinsurance	12 months or less to live.
If your child needs dental or eye care	Children's eye exam	$50/visit deductible does not apply	40% coinsurance	*See Vision Services section
	Children's glasses	20% coinsurance	40% coinsurance	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

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 excluded services.)

- Abortion
- Acupuncture
- Dental Check-up
- Cosmetic surgery
- Dental care (adult)
- Cosmetic agents
- Long- term care
- Fertility drugs
- Weight loss programs
- Routine foot care unless open cutting procedure or you are diagnosed with diabetes

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

- Chiropractic care
- Hearing aids 1/ear every 3 years through age 17.
- Infertility treatment $2,000 maximum/ lifetime for In-Network Providers.
- Routine eye care (adult) for In-Network Providers.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing only covered in the home. 40 visits/benefit period including home health 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, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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:

ATTN: Grievance and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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 the 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.