**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?** | **$250**/indiv., **$750**/family for in-network providers.<br><br>**$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?** | **$1,250**/indiv.; **$2,500**/family for coinsurance<br>**$3,500**/indiv.; **$7,000**/family for in-network providers.<br>**$15,000**/indiv.; **$30,000**/family for out-of-network providers.<br>**$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 | $25/visit deductible does not apply | 20% coinsurance | --------none-------- |
| | Specialist visit | $50/visit deductible does not apply | 20% 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) | 10% coinsurance | 20% coinsurance | --------none-------- |
| | Imaging (CT/PET scans, MRIs) | $100/visit deductible does not apply | 20% coinsurance | --------none-------- |
| **If you need drugs to treat your illness or condition** | Tier 1 - Typically Generic | $0 Co-payment for Generic Incentive Drugs<br>$15 Co-payment 34DS<br>$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.<br><br>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<br>$80 Co-payment 35-90DS(Mail Order) | N/A | |
| | Tier 3 - Typically Non-Preferred / Specialty Drugs | $75 Cop-payment 34DS<br>$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) | 10% coinsurance | 20% 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 | 10% coinsurance | 20% coinsurance | --------none-------- |
| **If you need immediate medical attention** | Emergency room care | $350/visit then 10% coinsurance | Covered as In-Network | If admitted inpatient or transported by ambulance, the ER copay is waived. |
| | Emergency medical transportation | 10% 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) | 10% coinsurance | 20% coinsurance | --------none-------- |
| | Physician/surgeon fees | 10% coinsurance | 20% 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 10% coinsurance | Office Visit 20% coinsurance Other Outpatient 20% coinsurance | Office Visit --------none-------- Other Outpatient --------none-------- |
| | Inpatient services | 10% coinsurance | 20% coinsurance | --------none-------- |
| **If you are pregnant** | Office visits | 10% coinsurance | 20% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 10% coinsurance | 20% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 20% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 20% coinsurance | 40 visits/benefit period including private duty nursing. |
| | Rehabilitation services | 10% coinsurance | 20% coinsurance | *See Therapy Services section |
| | Habilitation services | 10% coinsurance | 20% coinsurance | |
| | Skilled nursing care | 10% coinsurance | 20% 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 | 10% coinsurance | 20% coinsurance | *See Durable Medical Equipment Section |
| | Hospice services | 10% coinsurance | 20% 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 | 20% coinsurance | *See Vision Services section |
| | Children's glasses | 10% coinsurance | 20% 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
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Dental Check-up
- Long- term care
- Fertility drugs
- Cosmetic agents
- Weight loss programs / Appetite Suppressants
- 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: Grievances 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.

*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** **$250**
- **Specialist *copayment*** **$50**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

**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** | $250 |
| **Copayments** | $50 |
| **Coinsurance** | $1,000 |
| *What isn't covered* | |
| Limits or exclusions | $100 |
| **The total Peg would pay is** | **$1,400** |

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

- **The plan's overall deductible** **$250**
- **Specialist *copayment*** **$50**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

**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** | $100 |
| **Copayments** | $1795 |
| **Coinsurance** | $10 |
| *What isn't covered* | |
| Limits or exclusions | $40 |
| **The total Joe would pay is** | **$1,945** |

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

- **The plan's overall deductible** **$250**
- **Specialist *copayment*** **$50**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

**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** | $250 |
| **Copayments** | $350 |
| **Coinsurance** | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$700** |