

 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 1-844-353-1579. 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 1-844-353-1579 to request a copy. **For assistance with claims and medical benefits contact LEA Member Concierge Services at 1-844-353-1579.**

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| <p>What is the overall deductible?</p> | <p>Network providers: \$1,500 Individual / \$3,000 Family Out-of-network providers: \$3,000 Individual / \$6,000 Family Benefit Period: Plan Year</p> | <p>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 (Embedded).</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>Yes. Prescription Drugs, Preventive care, and primary care services are covered before you meet your deductible.</p> | <p>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/.</p> |
| <p>Are there other deductibles for specific services?</p> | <p>No.</p> | <p>You don't have to meet deductible for specific services.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>Network providers: \$3,000 Individual / \$6,000 Family Out-of-network providers: \$16,300 Individual \$32,000 Family Benefit Period: Plan Year</p> | <p>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 (Embedded).</p> |
| <p>What is not included in the out-of-pocket limit?</p> | <p>Premiums, balance-billing charges, penalties for failure to obtain Preauthorization for services, and health care this plan doesn't cover.</p> | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |
| <p>Will you pay less if you use a network provider?</p> | <p>Yes. This plan uses the National PPO (BlueCard PPO) Network. A list of network providers can be found at www.anthem.com or call 1-800-810-2583</p> | <p>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.</p> |
| <p>Do you need a referral to see a specialist?</p> | <p>No</p> | <p>You can see a specialist you choose without a referral</p> |



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 provider's office or clinic | Primary care visit to treat an injury or illness | Professional Non-Facility based services: \$25 copay /per visit Facility based services: 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | 50% coinsurance after deductible | None. |
| | Specialist visit to treat an injury or illness | Professional Non-Facility based services: \$45 copay /per visit Facility based services: 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | 50% coinsurance after deductible | None. |
| | Preventive care/screening/immunization | No Charge | 50% coinsurance after deductible | 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) | Office Setting or Independent Lab: 20% coinsurance (Deductible Waived) Facility based services: 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | 50% coinsurance after deductible | None. |
| | Imaging (CT/PET scans, MRIs) | Office Setting or Independent Lab: 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> Facility based services: 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | 50% coinsurance after deductible | Sleep Studies are covered in the home at Office or Independent Lab Cost Share. Preauthorization is required or benefit will be denied. |



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) | |
| <p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.carelonrx.com or call 1-833-271-2374.</p> | Generic drugs (Tier 1) | <p>No cost for Preventive Rx Drugs</p> <p>30-day supply Retail: \$15 Copay</p> <p>Mail Order up to 90-day supply: \$30 Copay</p> <p>Prescription cost limitation of \$1,500 per drug/per fill applies. Drugs that cost over \$1,500 per 30 day and \$4,500 for a 90 day supply per prescription are excluded from coverage.</p> | Not Covered | <p>No Cost PPACA mandated drugs - In Network Only. Covers up to a 30-day supply (retail subscription); 31-90-day supply (mail order prescription).</p> <p>No Charge for ACA mandated generic medications. 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.</p> <p>The Rx Plan excludes Orphan Drugs.</p> |
| | Preferred brand drugs (Tier 2) | <p>30-day supply Retail: 20% of medication cost with \$45 minimum \$90 maximum</p> <p>Mail Order up to 90-day supply: 20% of medication cost with \$90 minimum \$180 maximum</p> <p>Prescription cost limitation of \$1,500 per drug/per fill applies. Drugs that cost over \$1,500 per 30 day and \$4,500 for a 90 day supply per prescription are excluded from coverage.</p> | Not Covered | |



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) | |
| | Non-preferred brand drugs (Tier 3) | 30-day supply Retail: 20% of medication cost with \$65 minimum \$130 maximum Mail Order up to 90-day supply: 20% of medication cost with \$130 minimum \$260 maximum Prescription cost limitation of \$1,500 per drug/per fill applies. Drugs that cost over \$1,500 per 30 day and \$4,500 for a 90 day supply per prescription are excluded from coverage. | Not Covered | |
| | Specialty drugs (Tier 4) | Not Covered | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | 50% coinsurance after deductible | Preauthorization is required for services. If Preauthorization required but not obtained benefit will be denied. |
| | Physician/surgeon fees | 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | 50% coinsurance after deductible | None. |
| If you need immediate medical attention | Emergency room care | \$500 copay /per visit (Deductible Waived) <i>Savings Plus Plan Benefit</i> | | ER copay is waived if admitted as inpatient. All facilities are covered as in-network subject to meeting “emergency” criteria. |
| | Emergency medical transportation | No Charge (Deductible Waived) <i>Savings Plus Plan Benefit</i> | | All facilities are covered as in-network subject to meeting “emergency” criteria. |
| | Urgent care | \$75 copay /per visit (Deductible Waived) | | All Urgent Care Services are covered as in-network. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | 50% coinsurance after deductible | Preauthorization is required or benefit will be denied. |



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| 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) | |
| | Physician/surgeon fees | 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | 50% coinsurance after deductible | None. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Professional Non-Facility based services: \$25 copay /per visit | 50% coinsurance after deductible | None. |
| | | Facility based services: 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | | |
| | Inpatient services | 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | 50% coinsurance after deductible | Preauthorization is required or benefit will be denied. |
| If you are pregnant | Office visits | Professional Non-Facility based services: No Charge (Deductible Waived) | 50% coinsurance after deductible | Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity for Dependent Daughters is not covered. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization is required for stays longer than 48 hours for vaginal birth or 96 hours for cesarean birth if Preauthorization is not obtained benefit will be denied.. |
| | | Facility based services: 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | | |
| | Childbirth/delivery professional services | No Charge (Deductible Waived) <i>Savings Plus Plan Benefit</i> | 50% coinsurance after deductible | |
| | Childbirth/delivery facility services | 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | 50% coinsurance after deductible | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance after deductible | 50% coinsurance after deductible | Maximum 60 visits per benefit period Preauthorization is required or benefit will be denied. |



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| 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) | |
| | Rehabilitation services | Professional Non-Facility based services: Visits 1-30: \$45 copay /per visit Visits 31-60: \$60 copay /per visit Facility based services: 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | 50% coinsurance after deductible | Maximum 60 visits per benefit period. Combined limit for Rehabilitative / Habilitative services includes physical therapy, speech therapy, and occupational therapy. Combined In-Network and Out-of-Network limit. Preauthorization is required or benefit will be denied. |
| | Habilitation services | Professional Non-Facility based services: Visits 1-30: \$45 copay /per visit Visits 31-60: \$60 copay /per visit Facility based services: 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | 50% coinsurance after deductible | Maximum 60 visits per benefit period. Combined limit for Rehabilitative / Habilitative services includes physical therapy, speech therapy, and occupational therapy. Combined In-Network and Out-of-Network limit. Preauthorization is required or benefit will be denied. |
| | Skilled nursing care | 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | 50% coinsurance after deductible | Maximum 60 days per benefit period. Combined In-Network and Out-of-Network limit. Preauthorization is required or benefit will be denied. |
| | Durable medical equipment | 20% coinsurance after deductible | 50% coinsurance after deductible | Preauthorization is required for items. If Preauthorization required but not obtained benefit will be denied. |
| | Hospice services | Professional Non-Facility based services: 20% coinsurance after deductible Facility based Services: 20% coinsurance after deductible <i>Savings Plus Plan Benefit</i> | 50% coinsurance after deductible | Maximum 60 visits per benefit period Preauthorization is required or benefit will be denied. |
| 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. |



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| 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) | |
| | 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. |

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](#).)

| | | |
|---|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Ambulance Non-Emergency Transport • Bariatric Surgery • Cellular/Genetic Therapy • Cosmetic Surgery | <ul style="list-style-type: none"> • Dental Care (Adult) • Growth Hormones • Hearing Aids and Hearing Aid Exams • Infertility Comprehensive/Advanced Treatment • Long-term Care • Maternity Care for Dependent Child • Non-emergency care when traveling outside the U.S | <ul style="list-style-type: none"> • Non-Emergent Care in an ER Setting. • Orphan Disease & Orphan Drugs • Respite Care • Routine eye care (Adult) • Routine Foot Care • Sterilization Reversal • TMJ Treatment and Appliances • Weight Loss programs |
|---|---|---|

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

| | | |
|--|--|--|
| <ul style="list-style-type: none"> • Chiropractic Care (Limited to 30 visits per plan year) | <ul style="list-style-type: none"> • Private-duty Nursing (Excluded for Hospice care) | <ul style="list-style-type: none"> • Infertility Testing (Limited to basic testing) |
|--|--|--|

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. For more information on your rights to continue coverage, contact the plan at 1-844-353-1579. 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: 1-844-353-1579.

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 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 1-844-353-1579

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-353-1579

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-353-1579

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-353-1579

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](#) \$45
- 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 | \$12,687 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,500 |
| Copayments | \$30 |
| Coinsurance | \$1,470 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$3,000 |

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](#) \$45
- 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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles* | \$1,500 |
| Copayments | \$300 |
| Coinsurance | \$600 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$22 |
| The total Joe would pay is | \$2,420 |

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$45
- 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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles* | \$1,500 |
| Copayments | \$500 |
| Coinsurance | \$100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,100 |