
 **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, www.ACBLBenefits.com or call 1-866-885-1033. 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.ACBLBenefits.com or call 1-866-885-1033 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?		Network	Non-Network	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
	Per participant:	\$3,000	\$6,000	
	Per family:	\$6,000	\$12,000	
Are there services covered before you meet your deductible?	Yes, Network Preventive Care.			This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.			You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?		Network	Non-Network	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
	Per participant:	\$6,000	Unlimited	
	Per family:	\$12,000	Unlimited	
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>Plan</u> doesn't cover, charges in excess of benefit maximums, charges in excess of maximum allowed amounts, pre-certification penalties, and non-medically necessary services.			Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes, for medical: Anthem. See www.ACBLBenefits.com or call 1-866-885-1033 for a list of network providers. Yes, for prescription drugs: Express Scripts, Inc. For a list of retail and mail pharmacies, log on to			This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab

	www.express-scripts.com or call 1-866-885-1033.	work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	Home visits are covered.
	<u>Specialist</u> visit	20% coinsurance	50% coinsurance	
	<u>Preventive care/screening/immunization</u>	No Charge, deductible waived	50% coinsurance	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% coinsurance	50% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Pre-certification is required for MRI/MRA and PET scans. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com	Generic drugs	20% coinsurance	Not Covered	Retail: limited to a thirty-four (34) day supply.
	Preferred brand drugs	20% coinsurance	Not Covered	Mail Order: limited to a one hundred (100) day supply.
	Non-preferred brand drugs	20% coinsurance	Not Covered	Not all <u>prescription drugs</u> are covered. To determine if a specific drug is covered under your <u>plan</u> , log into your account at www.express-scripts.com .
	<u>Specialty drugs</u>	**Retail: 20% coinsurance, up to \$150 **Mail Order: 20% coinsurance, up to \$300	Not Covered	If you obtain <u>prescription drugs</u> from a non-network pharmacy, you will be required to pay the full cost of the prescription. For maintenance medications, the <u>Plan</u> only covers the cost of the original prescription plus two (2) retail pharmacy refills. Following the

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		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				two (2) retail refills, plan participants must utilize mail order to obtain the medication. Some drugs may require prior authorization. If not obtained, the drug may not be covered. **Specialty drugs are only covered when obtained through Accredo Specialty Pharmacies. Call 1-800-803-2523 for further information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Pre-certification is required. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	—————none—————
If you need immediate medical attention	<u>Emergency room care</u>	20% coinsurance		<u>Network deductible</u> applies to non- <u>network</u> services.
	<u>Emergency medical transportation</u>	20% coinsurance		
	<u>Urgent care</u>	20% coinsurance	50% coinsurance	Retail clinics are covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Pre-certification is required. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	—————none—————

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Pre-certification is required for intensive outpatient services and partial hospitalization services. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.
	Inpatient services	20% coinsurance	50% coinsurance	Pre-certification is required. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Pre-certification is required for inpatient stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.
If you need help recovering or have other special needs	<u>Home health care</u>	20% coinsurance	50% coinsurance	Calendar Year Maximum: one hundred and twenty (120) visits. Home infusion services do not apply to the <u>home health care</u> calendar year maximum. Pre-certification is required. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.
	<u>Rehabilitation services</u>	20% coinsurance	50% coinsurance	Calendar Year Maximum: thirty-six (36) visits for occupational therapy, thirty-six (36) visits for speech therapy, thirty-six (36) visits for cardiac rehabilitation, and thirty-six (36) visits

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<u>Habilitation services</u>	20% coinsurance	50% coinsurance	for pulmonary rehabilitation. <u>Inpatient rehabilitation services</u> apply to the <u>skilled nursing care</u> calendar year maximum. Therapy provided in the home when not rendered as part of a <u>home health care</u> plan applies to above maximums.
	<u>Skilled nursing care</u>	20% coinsurance	50% coinsurance	Calendar Year Maximum: one hundred and twenty (120) days combined with inpatient rehabilitation facilities. Pre-certification is required. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.
	<u>Durable medical equipment</u>	20% coinsurance	50% coinsurance	Repair/replacement are covered. Pre-certification is required for all rentals and any purchase over \$1,500. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.
	<u>Hospice services</u>	20% coinsurance	50% coinsurance	Lifetime Maximum: three hundred and sixty-five (365) days. Pre-certification is required. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	_____none_____
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.ACBLBenefits.com.

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 (except for newborn children or when due to trauma or disease)
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S. (except Global Core)
- Private-Duty Nursing
- Routine Eye Care
- Routine Foot Care (except for plan participants with diabetes)
- Weight Loss Programs

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

- Bariatric Surgery (limited to a diagnosis of morbid obesity)
- Chiropractic Care [limited to twelve (12) visits per calendar year]
- Hearing Aids (limited to \$5,000 for all hearing services per calendar 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Plan's COBRA Administrator, Wex Health, at 1-866-451-3399. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Care Coordinators for further information. The Care Coordinator's name, address, and telephone number are:

Quantum Health Care Coordinators
5240 Blazer Way
Dublin OH 43017
1-866-885-1033

* For more information about limitations and exceptions, see the plan or policy document at www.ACBLBenefits.com.

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 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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-885-1033.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-885-1033.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-885-1033.

Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwijigo holne' 1-866-885-1033.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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 \$3,000
- Specialist cost sharing 20%
- Hospital (facility) cost sharing 20%
- Other cost sharing 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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$4,920

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$3,000
- Specialist cost sharing 20%
- Hospital (facility) cost sharing 20%
- Other cost sharing 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,200
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,200

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$3,000
- Specialist cost sharing 20%
- Hospital (facility) cost sharing 20%
- Other cost sharing 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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