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, visit 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 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.
	Per participant:	$750	$1,500	
	Per family:	$1,500	$3,000	
Are there services covered before you meet your deductible?	**Yes.** The following in-network services are covered before the in-network deductible is met: preventive care, emergency room facility services (in-network and non-network), urgent care services, well newborn baby care, outpatient therapy services, outpatient chemotherapy/radiation, chiropractic care, telemedicine services, outpatient mental health/substance use disorder services, and prescription drugs. Certain in-network services when performed in an office setting (advanced imaging, hearing exams, lab & x-rays, ostomy supplies) are also covered before the deductible is met.			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?	No.			You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Medical Out-of-Pocket**			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.
		Network	**Non-Network**	
	Per participant:	$4,000	Unlimited	
	Per family:	$8,000	Unlimited	

	Prescription Drug Out-of-Pocket		
		Network	Non-Network
	Per participant:	$4,000	Unlimited
	Per family:	$8,000	Unlimited
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this Plan doesn't cover, charges in excess of benefit maximums, charges in excess of maximum allowed amounts, pre-certification penalties, and non-medically necessary services. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied toward satisfying your out-of-pocket limits.		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, 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 www.express-scripts.com or call 1-866-885-1033.		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)	Non-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 copayment, deductible waived	50% coinsurance	The office visit co-payment will apply to the office visit and all other office services, including lab and x-rays. Home visits are covered.
	Specialist visit	$35 copayment, deductible waived	50% coinsurance	

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

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)	
	Preventive care/screening/ immunization	No Charge, deductible waived	50% coinsurance	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	50% coinsurance	——————————none——————————
	Imaging (CT/PET scans, MRIs)	20% co-insurance	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 **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	**Retail:** $10 copayment/rx, deductible waived **Mail Order:** $25 copayment/rx, deductible waived	Not Covered	**Retail:** limited to a thirty-four (34) day supply. **Mail Order:** limited to a one hundred (100) day supply. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.express-scripts.com. If you obtain prescription drugs from a non-network pharmacy, you will be required to pay the full cost of the prescription. For maintenance medications, the Plan only covers the cost of the original prescription plus two (2) retail pharmacy refills. Following the 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. Please see "Important Questions" regarding
	Preferred brand drugs	**Retail:** $40 copayment/rx, deductible waived **Mail Order:** $100 copayment/rx, deductible waived	Not Covered	
	Non-preferred brand drugs	**Retail:** $75 copayment/rx, deductible waived **Mail Order:** $190 copayment/rx, deductible waived	Not Covered	
	Specialty drugs	**Retail:** 20% coinsurance, deductible waived up to	Not Covered	

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

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)	
		$150 **Mail Order: 20% coinsurance, deductible waived up to $300		the Plan's out-of-pocket limit for additional information on Specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copayment/visit, deductible waived	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	Emergency room care	$250 copayment/visit, deductible waived		The emergency room care co-payment will apply to the emergency room care visit and all other services, including lab and x-rays. Copayment is waived if the plan participant is admitted to an inpatient stay.
	Emergency medical transportation	20% coinsurance		Network deductible applies to non-network services.
	Urgent care	$35 copayment, deductible waived	50% coinsurance	The urgent care co-payment will apply to the urgent care visit and all other services, including lab and x-rays. 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——————————

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

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	$10 copayment/visit, deductible waived	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	**First Visit Only:** $35 copayment, deductible waived **All Other Visits:** 20% co-insurance	50% coinsurance	Routine pre-natal care is covered at no charge after initial visit. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). **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.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special needs	Home health care	20% coinsurance	50% coinsurance	**Calendar Year Maximum**: one hundred and twenty (120) visits. Home infusion services do not apply to the home health care calendar year maximum. **Pre-certification is required.** Failure to obtain pre-certification may result in a $500 reduction in benefits paid by the Plan.

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

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)	
	Rehabilitation services	**Inpatient Rehabilitation Services:** 20% coinsurance **Outpatient:** $35 copayment/visit, deductible waived	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 for pulmonary rehabilitation. Inpatient rehabilitation services apply to the skilled nursing care calendar year maximum. Therapy provided in the home when not rendered as part of a home health care plan applies to above maximums.
	Habilitation services			
	Skilled nursing care	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.
	Durable medical equipment	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.
	Hospice services	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

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.

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

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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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* For more information about limitations and exceptions, see the plan or policy document at www.ACBLBenefits.com.

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	$750
Specialist copayment	$35
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,080**

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

The plan's overall deductible	$750
Specialist copayment	$35
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$890**

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

The plan's overall deductible	$750
Specialist copayment	$35
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$500
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,340**

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