




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 your claims administrator: Anthem – 866-645-3269 or www.anthem.com; Express Scripts for [prescription drugs](#) – 877-861-0398 or www.express-scripts.com. 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 866-645-3269 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,500 employee; \$2,350 employee + eligible spouse or employee + child(ren); \$3,100 family	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 policy, the overall family deductible must be met before the plan begins to pay. This plan makes an annual allocation to a Health Reimbursement Account (HRA), which is automatically used to help meet your annual deductible . Copayments do not apply to your deductible .
Are there services covered before you meet your deductible?	Yes. Preventive care , virtual visits, and prescription drugs are covered before you meet your deductible .	This plan covers some items and services even if you have not 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 do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For Network providers : \$3,000 employee; \$5,000 employee + eligible spouse or employee + child(ren); \$7,000 family. For Out-of-Network providers : \$7,450 employee; \$12,750 for employee + eligible spouse or employee + child(ren); \$17,350 family.	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 , the overall family out-of-pocket limit must be met. Your annual out-of-pocket limit includes the amount you spend toward your annual deductible , copayments , and your coinsurance amounts.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain preauthorization for services, retail refill allowance penalty on prescription drugs , premiums , balance billing charges for Out-of-Network services, and health care this plan doesn't cover.	Even though you pay these expenses, they do not count toward the out-of-pocket limit .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. A listing of Network providers can be found by contacting the claim administrators at the numbers or websites listed at the top of page 1 of this document.	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)	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	10% coinsurance	30% coinsurance	Non-covered services or providers excluded.
	Specialist visit	10% coinsurance	30% coinsurance	Non-covered services or providers excluded.
	Preventive care/screening/immunization	No charge	You are responsible for any charges in excess of the allowed amount , otherwise no charge.	You may have to pay for services that are not 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	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	In some situations, you may need preauthorization for your procedure. Check with your claims administrator for more details. If preauthorization is not obtained when necessary, your claim could be denied as not covered.
If you need drugs to treat your illness or condition More information about prescription drug	Generic drugs	Retail up to 30-day supply: \$10 copayment Mail Order/Walgreens 90-day supply: \$20 copayment .	Retail: Reimbursed at in-network discounted rate less \$10 copayment	Covers up to a 30-day supply at any in-network retail pharmacy; up to a 90-day supply through mail order or at Walgreens. Your plan includes a limit on the number of times you can obtain certain long-term

* For more information about limitations and exceptions, see the [plan](#) or policy document by contacting the appropriate claims administrator: Anthem – 866-645-3269 or www.anthem.com; Express Scripts – 877-861-0398 or www.express-scripts.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
coverage is available at www.express-scripts.com .	Preferred brand drugs	Retail up to 30-day supply: 20% coinsurance with \$30 min. / \$80 max. Mail order/Walgreens 90-day supply: 20% coinsurance with \$75 min. / \$200 max.	Retail: Reimbursed at in-network discounted rate less 20% coinsurance with \$30 min. / \$80 max.	medications at your retail coinsurance . After the third purchase of a long-term prescription (such as those used to treat high blood pressure or high cholesterol) at your participating retail pharmacy that is not Walgreens, you will pay 75% coinsurance . Your extra cost will not apply toward your out-of-pocket limit . To avoid paying more for these prescriptions, purchase your long-term medications through mail order or at Walgreens. Copayments and coinsurance on brand name prescriptions apply to the annual out-of-pocket limit but not to the deductible .
	Non-preferred brand drugs	Retail up to 30-day supply: 35% coinsurance with \$45 min. / \$105 max. Mail order/Walgreens 90-day supply: 35% coinsurance with \$112 min. / \$262 max.	Retail: Reimbursed at in-network discounted rate less 35% coinsurance with \$45 min. / \$105 max.	
	Specialty drugs	Same as Non-preferred brand drugs above	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	In some situations, you may need preauthorization for your procedure. Check with your claims administrator for more details. If preauthorization is not obtained when necessary, your claim could be denied as not covered.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Medically necessary assistant surgeon allowable charges are limited to a percentage of primary surgeon's allowable charge.
If you need immediate	Emergency room care	10% coinsurance plus \$200 copayment , which	10% coinsurance plus \$200 copayment , which	If out-of-network provider used, paid at in-network rate and you are responsible for any

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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)	Out-of-Network Provider (You will pay the most)	
medical attention		is waived if admitted	is waived if admitted	charges in excess of the allowed amount . Claim may be denied if plan definition of emergency is not met.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Claim may be denied if plan definition of emergency is not met. If out-of-network provider used, you are responsible for any charges in excess of the allowed amount .
	Urgent care	10% coinsurance	30% coinsurance	Paid based on setting where covered services are received. Be aware that some facilities may bill services as emergency room care .
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	In some situations, you may need preauthorization for your procedure. Check with your claims administrator for more details. If preauthorization is not obtained when necessary, your claim could be denied as not covered.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	Medically necessary assistant surgeon allowable charges are limited to a percentage of primary surgeon's allowable charge.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	In some situations, you may need preauthorization for your procedure. Check with your claims administrator for more details. If preauthorization is not obtained when necessary, your claim could be denied as not covered.
	Inpatient services	10% coinsurance	30% coinsurance	In some situations, you may need preauthorization for your procedure. Check with your claims administrator for more details. If preauthorization is not obtained when necessary, your claim could be denied

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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)	Out-of-Network Provider (You will pay the most)	
				as not covered.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	120 visit limit per year
	Rehabilitation services	10% coinsurance	30% coinsurance	30 visit limit per year for each for physical, occupational and speech therapy, acupuncture, and spinal manipulations. In some situations, you may need preauthorization . Check with your claims administrator for more details. If preauthorization is not obtained when necessary, your claim could be denied as not covered.
	Habilitation services	10% coinsurance	30% coinsurance	Treatment must be proven and administered by a licensed professional.
	Skilled nursing care	10% coinsurance	30% coinsurance	100 visit limit per year for Outpatient Private Duty Nursing 120 visit limit per year for Inpatient Skilled Nursing Facility
	Durable medical equipment	10% coinsurance	30% coinsurance	In some situations, you may need preauthorization . Check with your claims administrator for more details. If preauthorization is not obtained when necessary, your claim could be denied as not covered.
	Hospice services	10% coinsurance	30% coinsurance	Care must be provided by a licensed hospice agency.

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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)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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"> • Bariatric Surgery • Cosmetic Surgery • Dental care 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing (in-patient) 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Acupuncture • Chiropractic care 	<ul style="list-style-type: none"> • Hearing Aids 	<ul style="list-style-type: none"> • Fertility treatment

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 at 866-444-EBSA or www.dol.gov/ebsa/healthreform and Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 877-267-2323 x61565 or www.cciio.cms.gov. 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 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 on how 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:

Anthem Blue Cross and Blue Shield, ATTN: [Grievances](#) and [Appeals](#)
P.O. Box 54159
Los Angeles, CA 90054-0159
866-645-3269

Express Scripts, Attn: Clinical [Appeals](#) Department
P.O. Box 66588
St. Louis, MO 63166-6588
877-861-0398

You may also contact the **Charter Benefits Center at 833-HR4-CHTR** or the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA or www.dol.gov/ebsa/healthreform.

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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 Anthem 866-645-3269; Express Scripts 877-861-0398.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa Anthem 866-645-3269; Express Scripts 877-861-0398.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 Anthem 866-645-3269; Express Scripts 877-861-0398.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' Anthem 866-645-3269; Express Scripts 877-861-0398.

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](#) \$1,500
- [Specialist coinsurance](#) 10%
- 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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$10
Coinsurance	\$1,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is (before HRA provided by Plan)	\$2,670

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 coinsurance](#) 10%
- 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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$100
Coinsurance	\$700
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is (before HRA provided by Plan)	\$3,280

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist coinsurance](#) 10%
- 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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$10
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is (before HRA provided by Plan)	\$1,190

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.