

 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, 1-844-399-6832. 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](http://www.healthcare.gov/sbc-glossary) or call 1-844-399-6832 to request a copy. **For assistance with claims and medical benefits contact LEA Member Services Concierge at 1-844-399-6832.**


Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network providers</a> : \$2,500 individual / \$5,000 family <a href="#">Out-of-network providers</a> : \$10,000 individual / \$10,000 family <b>Benefit Period: Calendar Year</b>	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> (Embedded).
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Prescription drugs</a> , <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network providers</a> : \$6,000 individual / \$12,000 family <a href="#">Out-of-network providers</a> : \$25,000 individual / \$50,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met (Embedded).
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">Preauthorization</a> for services, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. This plan uses the <b>National PPO (BlueCard PPO) Network</b> . A list of <a href="#">network providers</a> can be found at <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-810-2583	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see a <a href="#">specialist</a> you choose without a <a href="#">referral</a>

 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 <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	<b>Professional Non-Facility based services:</b> \$45 <a href="#">copay</a> /per visit <b>Facility based services:</b> 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Telemedicine for medical and mental/behavioral health provided by Live Health Online at 1-888-548-3432 or <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> .
	<a href="#">Specialist</a> visit to treat an injury or illness	<b>Professional Non-Facility based services:</b> \$75 <a href="#">copay</a> /per visit <b>Facility based services:</b> 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Telemedicine for medical and mental/behavioral health provided by Live Health Online at 1-888-548-3432 or <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> .
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<b>Office or Independent Lab:</b> 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <b>Facility based services:</b> 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Imaging (CT/PET scans, MRIs)	<b>All Settings:</b> 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.carelonrx.com">www.carelonrx.com</a> or call 1-833-271-2374</p>	Generic drugs (Tier 1)	<p>\$15 <a href="#">copay</a> Retail \$37.50 <a href="#">copay</a> Mail Order</p> <p>Prescription cost limitation of \$10,000 per drug/per fill applies. Drugs that cost over \$10,000 per 30 day and \$30,000 for a 90 day supply per prescription are excluded from coverage.</p>	<p>\$15 <a href="#">copay</a> Retail Only</p> <p>Prescription cost limitation of \$10,000 per drug/per fill applies. Drugs that cost over \$10,000 per 30 day and \$30,000 for a 90 day supply per prescription are excluded from coverage.</p>	<p>Covers up to a 30-day supply (retail subscription); 31-90-day supply (mail order prescription). 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>
	Preferred brand drugs (Tier 2)	<p>\$50 <a href="#">copay</a> Retail \$125 <a href="#">copay</a> Mail Order</p> <p>Prescription cost limitation of \$10,000 per drug/per fill applies. Drugs that cost over \$10,000 per 30 day and \$30,000 for a 90 day supply per prescription are excluded from coverage.</p>	<p>\$50 <a href="#">copay</a> Retail Only</p> <p>Prescription cost limitation of \$10,000 per drug/per fill applies. Drugs that cost over \$10,000 per 30 day and \$30,000 for a 90 day supply per prescription are excluded from coverage.</p>	
	Non-preferred brand drugs (Tier 3)	<p>\$85 <a href="#">copay</a> Retail \$212.50 <a href="#">copay</a> Mail Order</p> <p>Prescription cost limitation of \$10,000 per drug/per fill applies. Drugs that cost over \$10,000 per 30 day and \$30,000 for a 90 day supply per prescription are excluded from coverage.</p>	<p>\$85 <a href="#">copay</a> Retail Only</p> <p>Prescription cost limitation of \$10,000 per drug/per fill applies. Drugs that cost over \$10,000 per 30 day and \$30,000 for a 90 day supply per prescription are excluded from coverage.</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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Specialty drugs</a> (Tier 4)	All Specialty Drugs are Excluded: Contact Payer Matrix for assistance at 1-877-305-6202 9am - 8pm EST M-F.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required or benefit will be denied.
	Physician/surgeon fees	40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$500 <a href="#">copay</a> /per visit <i>Savings Plus Plan Benefit</i>		ER <a href="#">copay</a> is waived if admitted as inpatient. All facilities are covered as in-network subject to meeting “emergency” criteria.
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>		All facilities are covered as in-network subject to meeting “emergency” criteria. Network <a href="#">deductible</a> applies for Out-of-Network
	<a href="#">Urgent care</a>	\$75 <a href="#">copay</a> /per visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required or benefit will be denied.
	Physician/surgeon fees	40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<b>Professional Non-Facility based services:</b> \$45 <a href="#">copay</a> /per visit	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Virtual visits: \$10 <a href="#">copay</a> /per visit
		<b>Facility based services:</b> 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>		Telemedicine for medical and mental/behavioral health provided by Live Health Online at 1-888-548-3432 or <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> .

 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)	
	Inpatient services	40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required or benefit will be denied.
If you are pregnant	Office visits	<b>Professional Non-Facility based services:</b> \$45 <a href="#">copay</a> Copay applies to first prenatal visit per pregnancy.	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <a href="#">Preauthorization</a> is required for inpatient maternity stay if stay is beyond 48 hours for vaginal delivery or 96 hours for cesarean delivery. If <a href="#">Preauthorization</a> is required and not obtained benefit will be denied.
		<b>Facility based services:</b> 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>		
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required or benefit will be denied.
	<a href="#">Rehabilitation services</a>	<b>Professional Non-Facility based services:</b> 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Maximum <b>60</b> visits per benefit period. Combined INN/OON limit. Includes physical therapy, speech therapy, and occupational therapy. <a href="#">Preauthorization</a> is required or benefit will be denied.
		<b>Facility based services:</b> 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>		
	<a href="#">Habilitation services</a>	<b>Professional Non-Facility based services:</b> 40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
<b>Facility based services:</b> 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>				
<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Maximum <b>45</b> visits per benefit period. <a href="#">Preauthorization</a> 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required or benefit will be denied.
	<a href="#">Hospice services</a>	<b>Home setting:</b> 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <b>Facility setting:</b> 40% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Maximum <b>45</b> days per lifetime. <a href="#">Preauthorization</a> 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.
	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](#).)

- Acupuncture
- Alternative Medicine/homeopathy
- Aquatic Therapy
- Arch supports (supportive shoe inserts)
- Biofeedback
- Cardiac Rehabilitation
- Cosmetic Surgery (exclusion does not apply to breast reconstruction post-mastectomy)
- Custodial Care
- Dental Care (Routine) Adult and Child except ACA allowed
- Dialysis/Hemodialysis
- Foot Care (routine) – Non-Diabetic
- Gene / Cellular Therapy
- Growth Hormone Therapy
- Halfway house/home – non-healthcare residential facility
- Hearing Aids
- Home visits – Professional (not part of Home Health visits/ Home Health Aid Services)
- Infertility Services – Comprehensive (AI) & Advanced (ZIFT/GIFT/IVF)
- Long-Term Care
- Massage Therapy
- Medical Nutrition Products – PKU formulas and enteral feeding supplies.
- Medical Nutrition Therapy
- Non-Emergency Care outside the U.S.
- Orthopedic Shoes/ orthopedic inserts – Non-diabetic
- Orthoptic / Pleoptic Therapy
- Private Duty Nursing
- Respite Care
- Routine Eye Care (Adult) and Child except ACA allowed
- Self-Inflicted unless result of medical condition
- Sterilization Reversals
- Vision Exam and Hardware
- 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
- Chiropractic care (Chiropractic and Osteopathic manipulation limited to 30 visits 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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). For more information on your rights to continue coverage, contact the plan at 1-844-399-6832. 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](http://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: 1-844-399-6832.

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual mark 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 1-844-399-6832

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-399-6832

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-844-399-6832

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-399-6832

*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](#) \$2,500
- [Specialist copayment](#) \$75
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$10
Coinsurance	\$3,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,060</b>

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist copayment](#) \$75
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$900
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,720</b>

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist copayment](#) \$75
- Hospital (facility) [coinsurance](#) 40%
- Other [coinsurance](#) 40%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$1,700
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,300</b>