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 1-844-426-9443. 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 1-844-426-9443 to request a copy. **For assistance with claims and medial benefits contact LEA Member Services Concierge at 1-844-426-9443.**

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: $0 Individual / $0 Family Out-of-network providers: Not Covered **Benefit Period: Plan Year**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	N/A	This plan has no 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 deductible for specific services.
What is the out-of-pocket limit for this plan?	Network providers: $7,350 Individual / $14,700 family Out-of-network providers: Not Covered	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain Preauthorization for services, and health care this plan doesn't cover.	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. 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.**	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 a 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: Preferred Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
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:** $25 copay/ per visit *Savings Plus Plan Benefit*	Not Covered	Limit of 8 visits per Plan year.
	Specialist visit to treat an injury or illness	**Professional Non-Facility based services:** $50 copay/per visit **Facility based services:** $50 copay/per visit *Savings Plus Plan Benefit*	Not Covered	Limit of 8 visits per Plan year.
	Preventive care/screening/ immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab & Pathology: Office or Independent Lab**: $50 copay/per visit **Radiology: Office or Independent Lab**: $50 copay/per visit **Lab & Pathology: Facility based services:** $50 copay/per visit *Savings Plus Plan Benefit* **Radiology: Facility based services:** $50 copay/per visit *Savings Plus Plan Benefit*	Not Covered	Limited to 3 visits per Plan year. Combined limit radiology and laboratory services.
	Imaging (CT/PET scans, MRIs)	**Office or Independent Lab**: $350 Co-pay/ per visit **Facility based services:** $350 Co-pay/ per visit *Savings Plus Plan Benefit*	Not Covered	Limited to 1 visit per Plan year. Preauthorization is required or benefit will be denied.

For more information about limitations and exceptions, contact 1-844-426-9443

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 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**	Generic drugs (Tier 1)	$0 for Preventive Medicine **1-90 day supply:** 20% copay Prescription cost limitation of $1,000 per drug/per fill applies. Drugs that cost over $1,000 per 30 day prescription are excluded from coverage.	Not Covered	Subject to formulary. Retail: 0-30 day supply Mail Order: 31-90 day supply
	Preferred brand drugs (Tier 2)	**1-90 day supply:** 20% copay Prescription cost limitation of $1,000 per drug/per fill applies. Drugs that cost over $1,000 per 30 day prescription are excluded from coverage.	Not Covered	Subject to formulary
	Non-preferred brand drugs (Tier 3)	Not Covered	Not Covered	None.
	Specialty drugs (Tier 4)	Not Covered	Not Covered	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 copay/per visit *Savings Plus Plan Benefit*	Not Covered	Limited to 1 Outpatient Surgery per Plan year. Anesthesia Limited to 1 Outpatient anesthetic procedure per plan year included in Outpatient Facility Benefit. Preauthorization is required or benefit will be denied.
	Physician/surgeon fees	No charge *Savings Plus Plan Benefit*	Not Covered	Included in Outpatient Facility or Free-standing facility services and Surgery Copay.
If you need immediate medical attention	Emergency room care	$350 Co-pay/ per visit *Savings Plus Plan Benefit*		Limited to 1 Emergency Room visit per Plan year.
	Emergency medical transportation	$250 Co-pay/ per trip *Savings Plus Plan Benefit*		Limited to 1 Emergency Medical Transportation trip per Plan year. **Ground ambulance only.**
	Urgent care	$50 copay/per visit	Not Covered	Limited to 2 Urgent Care visits per Plan

For more information about limitations and exceptions, contact 1-844-426-9443

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)	
				year.
If you have a hospital stay	Facility fee (e.g., hospital room)	$350 Co-pay/ per admission *Savings Plus Plan Benefit*	Not Covered	Limited to 5 Inpatient days per Plan year. (Inpatient Maternity excluded) Preauthorization is required for inpatient services or benefit will be denied.
	Physician/surgeon fees	No charge	Not Covered	Limited to 5 Physician visit days per plan year. Limited to 2 Inpatient Surgeries per plan year. Anesthesia services are limited to 2 Inpatient anesthetic procedures per plan year.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Professional Non-Facility based services:** $25 copay/per visit **Facility based services:** $25 copay/per visit	Not Covered	Limited to 8 visits per Plan year. Cost sharing does not apply for preventive services.
	Inpatient services	$250 copay/per admission *Savings Plus Plan Benefit*	Not Covered	Limited to 5 days per Plan year. Preauthorization is required for inpatient services or benefit will be denied
If you are pregnant	Office visits	**Professional Non-Facility based services:** Not Covered **Facility based services:** Not Covered	Not Covered	Cost sharing does not apply for preventive services, some prenatal testing, screenings, and laboratory services.
	Childbirth/delivery professional services	Not Covered	Not Covered	None.
	Childbirth/delivery facility services	Not Covered	Not Covered	None.

For more information about limitations and exceptions, contact 1-844-426-9443

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 need help recovering or have other special health needs	Home health care	$25 copay/per visit	Not Covered	Limited to 10 visits per Plan year Preauthorization is required or benefit will be denied.
	Rehabilitation services	Not covered	Not covered	None
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	Not covered	Not covered	None
	Durable medical equipment	Not covered	Not covered	None
	Hospice services	Not covered	Not covered	None
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.)

- Abortion
- Acupuncture
- Aquatic therapy
- Bariatric surgery
- Biofeedback
- Chemotherapy
- Chiropractic care
- Cosmetic surgery (not related to Mastectomy)
- Dental care (Adult and Child) other than ACA mandated
- Dialysis/Hemodialysis therapy
- Durable medical equipment
- Genetic testing other than ACA mandated
- Glasses (Adult)
- Habilitative services
- Halfway house/home
- Hearing aids
- Hospice services
- Infertility treatment / services
- Long-term care
- Massage therapy
- Maternity Care for a Dependent Child
- Non-emergency care when traveling outside the U.S.
- Primary Care Physician (PCP) Surgery
- Private-duty nursing
- Radiation Therapy
- Rehabilitation services
- Routine eye care (Adult)
- Routine foot care
- Sex reassignment/change procedures and investigational studies.
- Sexual dysfunction
- Skilled nursing facilities
- Sleep Management/Sleep Studies
- TMJ Treatment and Appliances
- Transplants and Transplant services
- Weight loss programs

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

- Diagnostic test (x-ray, blood work)
- Emergency medical transportation
- Emergency room services
- Facility fee (e.g., hospital room)
- Imaging (CT / PET scans, MRIs)
- Inpatient Services
- Physician / surgeon fees
- Urgent care

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 1-844-426-9443. 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: 1-844-426-9443.

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 1-844-426-9443
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-426-9443
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-426-9443
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-426-9443

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

For more information about limitations and exceptions, contact 1-844-426-9443

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	$0
Specialist copayment	$50
Hospital (facility) coinsurance	100%
Other coinsurance	100%

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:

Cost Sharing	
Deductibles	$0
Copayments	$631
Coinsurance	$0
What isn't covered	
Limits or exclusions	$9,732
The total Peg would pay is	**$10,363**

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

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) coinsurance	100%
Other coinsurance	100%

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	**$5,601**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$557
Coinsurance	$0
What isn't covered	
Limits or exclusions	$3,938
The total Joe would pay is	**$4,495**

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

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) coinsurance	100%
Other coinsurance	100%

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*	$0
Copayments	$855
Coinsurance	$0
What isn't covered	
Limits or exclusions	$612
The total Mia would pay is	**$1,467**

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