



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 call 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](http://www.healthcare.gov/sbc-glossary) or call **LEA Member Services Concierge at 1-844-426-9443** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0 Individual / \$0 Family Benefit Period: Plan Year	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	N/A	This <a href="#">plan</a> has no <a href="#">deductible</a> . See a list of covered preventive services 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="#">deductible</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> : \$0 individual / \$0 family <a href="#">Out-of-network providers</a> : Not Covered	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Not Applicable	This <a href="#">plan</a> does not have an <a href="#">out-of-pocket limit</a> on your expenses.
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 the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	Not Covered	Not Covered	No coverage for primary care.
	<a href="#">Specialist</a> visit	Not Covered	Not Covered	No coverage for specialist care.
	<a href="#">Preventive care/screening/immunization</a>	No Charge	No Charge	Includes <a href="#">preventive</a> health services specified in the health care reform law. No coverage non-network. No coverage if services provided in a hospital setting.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Not Covered	Not Covered	No coverage for diagnostic tests.
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	No coverage for imaging.
<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	Generic drugs	Preventive Drugs Only Retail: \$0 Copay	Not Covered	No coverage for prescription drugs, except for Generic Preventive and Generic Contraceptives covered at No Charge. Retail: Up to a 30-day supply If you use a non-network pharmacy, you are responsible for any amount.
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	<a href="#">Specialty drugs</a>	Not Covered	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	No coverage for facility fee.
	Physician/surgeon fees	Not Covered	Not Covered	No coverage for physician/surgeon fees.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Not covered		No coverage for emergency room services.
	<a href="#">Emergency medical transportation</a>	Not Covered	Not Covered	No coverage for emergency medical transportation.
	<a href="#">Urgent care</a>	Not Covered	Not Covered	No coverage for urgent care.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not Covered	Not Covered	No coverage for facility fee.
	Physician/surgeon fees	Not Covered	Not Covered	No coverage for physician/surgeon fees.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Not Covered	Not Covered	<a href="#">Preventive services</a> are covered for mental, behavioral health or substance abuse. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Partial hospitalization is not covered. No coverage for mental/behavioral health or substance abuse outpatient services.
	Inpatient services	Not Covered	Not Covered	No coverage for mental/behavioral health or substance abuse inpatient services.
<b>If you are pregnant</b>	Office visits	Preventive Prenatal: No Charge Routine Prenatal: Not Covered Postnatal: Not Covered	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> , some prenatal testing, screenings, and laboratory services.
	Childbirth/delivery professional services	Not Covered	Not Covered	No coverage for delivery or inpatient professional services.
	Childbirth/delivery facility services	Not Covered	Not Covered	No coverage for delivery or inpatient facility services.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Not Covered	Not Covered	No coverage for home health care.
	<a href="#">Rehabilitation services</a>	Not Covered	Not Covered	No coverage for rehabilitation services.
	<a href="#">Habilitation services</a>	Not Covered	Not Covered	No coverage for habilitative services.
	<a href="#">Skilled nursing care</a>	Not Covered	Not Covered	No coverage for skilled nursing care.
	<a href="#">Durable medical equipment</a>	Not Covered	Not Covered	Only ACA Mandated breast pumps are covered. No coverage for all other durable medical equipment.
	<a href="#">Hospice services</a>	Not Covered	Not Covered	No coverage for hospice service.
<b>If your child needs dental or eye care</b>	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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>• ABA Therapy</li> <li>• Abortion</li> <li>• Acupuncture</li> <li>• Aquatic therapy</li> <li>• Bariatric surgery</li> <li>• Biofeedback</li> <li>• Chemotherapy</li> <li>• Chiropractic care</li> <li>• Cosmetic surgery (not related to Mastectomy)</li> <li>• Dental care (Adult and Child) other than ACA mandated</li> <li>• Diagnostic test (x-ray, blood work)</li> <li>• Dialysis therapy</li> <li>• Durable medical equipment</li> <li>• Emergency medical transportation</li> <li>• Emergency room services</li> </ul>	<ul style="list-style-type: none"> <li>• Facility fee (e.g., hospital room)</li> <li>• Genetic testing other than ACA mandated</li> <li>• Gender Affirmation surgery</li> <li>• Glasses (Adult)</li> <li>• Growth Hormone treatment</li> <li>• Habilitative services</li> <li>• Halfway house/home</li> <li>• Hearing aids</li> <li>• Hospice services</li> <li>• Imaging (CT / PET scans, MRIs)</li> <li>• Infertility treatment / services</li> <li>• Inpatient Hospital services</li> <li>• Long-term care</li> <li>• Massage therapy</li> <li>• Maternity Pre/Post Natal &amp; delivery services beyond PPACA mandate</li> <li>• Maternity Care for dependent daughters</li> </ul>	<ul style="list-style-type: none"> <li>• Mental Health/Substance Abuse services IP/OP</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Physician / surgeon fees</li> <li>• Primary Care Physician (PCP) Surgery</li> <li>• Private-duty nursing</li> <li>• Radiation Therapy</li> <li>• Rehabilitation services</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Sexual dysfunction</li> <li>• Skilled nursing facilities</li> <li>• Sleep Management/Sleep Studies</li> <li>• Surgical inpatient services</li> <li>• Telemedicine</li> <li>• TMJ Treatment and Appliances</li> <li>• Transplants and Transplant services</li> <li>• Urgent Care</li> <li>• Weight loss programs</li> </ul>	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)			
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**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 x 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). For more information on your rights to continue coverage, contact the plan at 1-844-426-9443. 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](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: 1-844-426-9443.

**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? No.**

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, kwijigo holne' 1-844-426-9443

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	100%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,687</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$12,600
<b>The total Peg would pay is</b>	<b>\$12,600</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	100%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,601</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$5,400
<b>The total Joe would pay is</b>	<b>\$5,400</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$0
■ Hospital (facility) <a href="#">coinsurance</a>	100%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

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