**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 CareBPA at 1-877-208-5952. 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 1-877-208-5952 to request a copy. **For assistance with claims and medical benefits, contact LEA member Services Concierge at 1-877-208-5952.**

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network providers:<br>$6,550 individual / $13,100 family<br>Out-of-network providers:<br>$8,550 individual / $17,100 family<br>**Benefit Period: Calendar Year** | 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 (Embedded). |
| **Are there services covered before you meet your deductible?** | Yes. Prescription drugs, Preventive care, and primary care services are covered before you meet your deductible. | 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 deductible for specific services. |
| **What is the out-of-pocket limit for this plan?** | Network providers:<br>$8,150 Individual<br>$16,300 Family<br>Out-of-network providers:<br>$16,300 Individual<br>$32,600 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, 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 | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred 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 | **Professional Non-Facility based services:** $35 copay/per visit<br>**Facility based services:** No Charge after deductible<br>*Savings Plus Plan Benefit* | 50% coinsurance after deductible | None. |
| | Specialist visit to treat an injury or illness | **Professional Non-Facility based services:** $50 copay/per visit<br>**Facility based services:** No Charge after deductible<br>*Savings Plus Plan Benefit* | 50% coinsurance after deductible | None |
| | Preventive care/screening/ immunization | No Charge | 50% coinsurance after deductible | 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) | **Lab & Pathology: Office or Independent Lab**: $25 copay/per visit (deductible waived)<br>**Radiology: Office or Independent Lab**: $50 copay/per visit (deductible waived)<br>**Lab & Pathology: Facility based services:**$50 copay/per visit (deductible waived)<br>*Savings Plus Plan Benefit*<br>**Radiology: Facility based services:** $100 copay/per visit (deductible waived)<br>*Savings Plus Plan Benefit* | 50% coinsurance after deductible | None |
| | Imaging (CT/PET scans, MRIs) | **Office or Independent Lab**: $100 copay/per visit (deductible waived)<br>**Facility based services:** $200 copay/per visit (deductible waived)<br>*Savings Plus Plan Benefit* | 50% coinsurance after deductible | Preauthorization is required or benefit reduces by 20%.<br><br>Sleep Studies are covered in the home at Office or Independent Lab Cost Share. |

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) | **30 day supply:** Lesser of cost of medication or $10 copay Retail **31-90 day supply:** Lesser of cost of medication or $25 copay Mail Order | Not Covered | Covers up to a 30-day supply (retail subscription); 31-90-day supply (mail order prescription). **No Charge for ACA mandated generic medications.** **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.** |
| | Preferred brand drugs (Tier 2) | **30 day supply:** 35% of medication cost with a minimum of $30 and a maximum of $65 **31-90 day supply:** 35% of medication cost with a minimum of $65 and a maximum of $125 | Not Covered | |
| | Non-preferred brand drugs (Tier 3) | **30 day supply:** 50% of medication cost with a minimum of $45 and a maximum of $85 **31-90 day supply:** 50% of medication cost with a minimum of $90 and a maximum of $160 | Not Covered | |
| | Specialty drugs (Tier 4) | Not Covered | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge after deductible *Savings Plus Plan Benefit* | 50% coinsurance after deductible | Preauthorization is required for services. If Preauthorization required but not obtained benefit reduces by 20%. |
| | Physician/surgeon fees | No Charge after deductible *Savings Plus Plan Benefit* | 50% coinsurance after deductible | None |
| **If you need immediate medical attention** | Emergency room care | $500 copay/per visit (Deductible Waived) *Savings Plus Plan Benefit* | | ER copay is waived if admitted as inpatient. All facilities are covered as in-network subject to meeting "emergency" criteria. |
| | Emergency medical transportation | No Charge (Deductible Waived) *Savings Plus Plan Benefit* | | All facilities are covered as in-network subject to meeting "emergency" criteria. |
| | Urgent care | $50 copay/per visit (Deductible Waived) | $50 copay/per visit (Deductible Waived) | All facilities are covered as in-network. |

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 have a hospital stay** | Facility fee (e.g., hospital room) | No Charge after deductible<br>*Savings Plus Plan Benefit* | 50% coinsurance after deductible | Preauthorization is required or benefit reduces by $1,000. |
| | Physician/surgeon fees | No Charge after deductible<br>*Savings Plus Plan Benefit* | 50% coinsurance after deductible | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | **Professional Non-Facility based services:**<br>$35 copay/per visit<br>**Facility based services:**<br>No Charge after deductible<br>*Savings Plus Plan Benefit* | 50% coinsurance after deductible | None |
| | Inpatient services | No Charge after deductible<br>*Savings Plus Plan Benefit* | 50% coinsurance after deductible | Preauthorization is required or benefit reduces by $1,000. |
| **If you are pregnant** | Office visits | **Professional Non-Facility based services:**<br>No Charge (Deductible Waived)<br>**Facility based services:**<br>No Charge after deductible<br>*Savings Plus Plan Benefit* | 50% coinsurance after deductible | 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). Preauthorization is required for stays longer than 48 hours for vaginal birth or 96 hours for cesarean birth if Preauthorization is not obtained benefit reduces by $1,000. |
| | Childbirth/delivery professional services | No Charge (Deductible Waived)<br>*Savings Plus Plan Benefit* | 50% coinsurance after deductible | |
| | Childbirth/delivery facility services | No Charge after deductible<br>*Savings Plus Plan Benefit* | 50% coinsurance after deductible | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge after deductible | 50% coinsurance after deductible | Preauthorization is required or benefit reduces by 20%. |
| | Rehabilitation services | **Professional Non-Facility based services:**<br>**Visits 1-30:**$25 copay/per visit<br>**Visits 31-60:** $50 copay/per visit<br>**Facility based services:**<br>No Charge after deductible<br>*Savings Plus Plan Benefit* | 50% coinsurance after deductible | Maximum **60** visits per benefit period. Combined limit for Rehabilitative / Habilitative services includes physical therapy, speech therapy, and occupational therapy. Combined In-Network and Out-of-Network limit. Preauthorization is required or benefit reduces by 20%. |

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<br>Preferred Network Provider (You will pay the least) | What You Will Pay<br>Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | Habilitation services | **Professional Non-Facility based services:**<br>**Visits 1-30:**$25 copay/per visit<br>**Visits 31-60:** $50 copay/per visit<br><br>**Facility based services:**<br>No Charge after deductible<br>*Savings Plus Plan Benefit* | 50% coinsurance after deductible | Maximum **60** visits per benefit period. Combined limit for Rehabilitative / Habilitative services includes physical therapy, speech therapy, and occupational therapy. Combined In-Network and Out-of-Network limit. Preauthorization is required or benefit reduces by 20%. |
| | Skilled nursing care | No Charge after deductible<br>*Savings Plus Plan Benefit* | 50% coinsurance after deductible | Maximum **120** days per benefit period. Combined In-Network and Out-of-Network limit. Preauthorization is required or benefit reduces by $1,000. |
| | Durable medical equipment | No Charge after deductible | 50% coinsurance after deductible | Preauthorization is required for items. If Preauthorization required but not obtained benefit reduces by 20%. |
| | Hospice services | **Home Setting:**<br>No Charge after deductible<br><br>**Facility Setting:**<br>No Charge after deductible<br>*Savings Plus Plan Benefit* | 50% coinsurance after deductible | Preauthorization is required or benefit will be denied. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered<br>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<br>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 | • Hearing Aids and Hearing Aid Exams | • Routine eye care (Adult) |
| • Bariatric Surgery | • Gene/Cellular Therapy | • Routine Foot Care (non-diabetic) |
| • Biofeedback | • Long-term Care | • Specialty Medication (Rx and Medical) |
| • Cosmetic Surgery | • Maternity Care for Dependent child | • TMJ Treatment and Appliances |
| • Dental Care (Adult) | • Non-emergency care when traveling outside the U.S. | • Weight Loss programs |
| **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)** | | |
| • Chiropractic Care (Limited to 30 visits per calendar year) | • Infertility Treatment (Limited to $2,000 Max per Lifetime) | • Private-duty Nursing (Excluded for Hospice care)<br>• Respite Care (Limited to 7 days every 6 months) |

**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 1-877-208-5952. 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: 1-877-208-5952.

**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 1-877-208-5952
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-208-5952
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-208-5952
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-208-5952

*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 | $6,550 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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 | $6,550 |
| Copayments | $478 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $61 |
| **The total Peg would pay is** | **$7,089** |

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

| | |
|---|---|
| The plan's overall deductible | $6,550 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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* | $790 |
| Copayments | $1,022 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $22 |
| **The total Joe would pay is** | **$1,834** |

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

| | |
|---|---|
| The plan's overall deductible | $6,550 |
| Specialist copayment | $50 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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* | $248 |
| Copayments | $712 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$960** |

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