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 www.mycoresource.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.cciio.cms.gov or call 1-877-267-2323 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Preferred Providers**: **$750** person/**$2,250** family **Nonpreferred Providers**: **Unlimited** person/**Unlimited** 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 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.
Are there services covered before you meet your deductible?	Yes - true medical emergency services and the following **preferred provider** services: office visits, urgent care centers, hospice care, therapy services; preventive care and the prescription drug program.	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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Preferred Providers**: **$2,000** person/**$6,000** family **Nonpreferred Providers**: **Unlimited** person/**Unlimited** 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.
What is not included in the out-of-pocket limit?	Premiums, penalties for failure to pre-certify services, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

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Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See **www.anthem.com** or call **1-800-810-2583** for a list of participating providers.	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
		Preferred Provider (You will pay the least)	Nonpreferred 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	$25 copay/visit; (Deductible does not apply)	Not covered	None
	Specialist visit	$30 copay/visit; (Deductible does not apply)	Not covered	None
	Preventive care/screening/ immunization	No charge (Deductible does not apply.)	Not covered	You may have to pay for services that aren't 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)	20% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred 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.us-rxcare.com.	Generic drugs	$10 copay retail and $25 copay mail order/ prescription	Not covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). Prescription drug copays don't apply to preventive drugs.
	Preferred brand drugs	$35 copay retail and $50 copay mail order/ prescription	Not covered	
	Non-preferred brand drugs	$80 copay retail and $50 copay mail order/ prescription	Not covered	
	Specialty drugs	20% coinsurance up to maximum of $200/ prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$250 copay	$250 copay	Copay waived if admitted.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$30 copay	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay, then 20% coinsurance	Not covered	Pre-certification is required.
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay	Not covered	None
	Inpatient services	Facility: $500 copay, then 20% coinsurance; Professional: 20% coinsurance	Not covered	Pre-certification is required.

* For more information about limitations and exceptions, see the plan or policy document at www.mycoresource.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	Not covered	None
	Childbirth/delivery professional services	No charge	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copay, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (*i.e.*, ultrasound.)
	Childbirth/delivery facility services	$500 copay, then 20% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Coverage is limited to 120 visits/calendar year. Pre-certification is required.
	Rehabilitation services	Respiratory, Radiation and Chemotherapy: No charge; Other therapies: $25 copay	Not covered	Coverage is limited to 20 visits/calendar year for physical & occupational therapy, combined; 20 visits/calendar year for speech therapy and 30 visits/calendar year for respiratory therapy.
	Habilitation services	20% coinsurance	Not covered	None
	Skilled nursing care	No charge	Not covered	Coverage is limited to 30 days/calendar year. Pre-certification is required.
	Durable medical equipment	20% coinsurance	Not covered	None
	Hospice services	No charge	Not covered	Pre-certification is required for inpatient hospice care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for eye exams under medical.
	Children's glasses	Not covered	Not covered	No coverage for glasses under medical.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-ups under medical.

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;
- Bariatric surgery;
- Chiropractic care;
- Cosmetic surgery;
- Dental care;
- Hearing aids;
- Infertility treatment;
- Long-term care;
- Private-duty nursing;
- Routine eye care;
- Routine foot care, and
- Weight-loss programs.

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

Non-emergency care when traveling outside the U.S.

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's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: CoreSource at 1-877-279-5285 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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, see the plan or policy document at www.mycoresource.com.

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	$750
Specialist copay	$30
Hospital (facility) copay/coinsurance	$500/20%
Other coinsurance	20%

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$1,250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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

The plan's overall deductible	$750
Specialist copay	$30
Hospital (facility) copay/coinsurance	$500/20%
Other coinsurance	20%

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$920
Coinsurance	$330
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,060**

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

The plan's overall deductible	$750
Specialist copay	$30
Hospital (facility) copay/coinsurance	$500/20%
Other coinsurance	20%

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$260
Copayments	$90
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$410**

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