



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 **LEA Member Services Concierge** at 1-866-681-1110. 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 1-866-681-1110 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<p><a href="#">Network providers</a>: \$2,000 Individual / \$4,000 Family</p> <p><a href="#">Out-of-network providers</a>: \$12,700 Individual / \$25,400 Family</p> <p><b>Benefit Period: Calendar Year</b></p>	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. Prescription drugs, <a href="#">Preventive care</a> , Primary care, and Urgent 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="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<p><a href="#">Network providers</a>: \$9,450 Individual / \$18,900 Family</p> <p><a href="#">Out-of-network providers</a>: \$12,700 Individual / \$25,400 Family</p>	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
		Preferred 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</a> office or clinic	Primary care visit to treat an injury or illness	<b>Professional Non-Facility based services:</b> \$35 <a href="#">copayment</a> / per visit  <b>Facility based services:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	Telemedicine via Live Health Online is covered at the PCP/Specialist office cost share at <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> or 1-888-548-3432 Coverage includes Primary Care, Specialist Care, and Mental Health & Substance Use.
	<a href="#">Specialist</a> visit to treat an injury or illness	<b>Professional Non-Facility based services:</b> \$70 <a href="#">copayment</a> / per visit  <b>Facility based services:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	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 <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. Mammograms are limited to 1 per benefit period, ages 40 and over.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<b>Lab &amp; Pathology Office or Independent Lab:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	None
		<b>Radiology Office or Independent Lab:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>		
<b>Radiology / Lab &amp; Pathology Facility based services:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>				
Imaging (CT/PET scans, MRIs)		<b>Office or Independent Lab:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required or benefit reduces by 50%.
		<b>Facility based services:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</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
		Preferred Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<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.anthem.com">www.anthem.com</a> or call 1-833-271-2374	Generic drugs (Tier 1)	<b>No Cost for Preventive Rx Drugs</b> <b>Retail 30-day supply:</b> \$15 <a href="#">copayment</a> / per drug <b>Mail Order Up to 90-day supply:</b> \$37.50 <a href="#">copayment</a> / per drug	Not Covered	<b>Plan Deductible does not apply.</b>  Covers up to a 30-day supply (retail subscription); 1-90-day supply (mail order prescription).  <b>No Charge for ACA mandated generic medications.</b>  <b>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.</b> <b>No charge for ACA mandated generic medication.</b>
	Preferred brand drugs (Tier 2)	<b>Retail 30-day supply:</b> \$60 <a href="#">copayment</a> / per drug <b>Mail Order Up to 90-day supply:</b> \$150 <a href="#">copayment</a> / per drug	Not Covered	
	Non-preferred brand drugs (Tier 3)	<b>Retail 30-day supply:</b> \$120 <a href="#">copayment</a> / per drug <b>Mail Order Up to 90-day supply:</b> \$300 <a href="#">copayment</a> / per drug	Not Covered	
	<a href="#">Specialty drugs</a> (Tier 4)	<b>Retail 30-day supply:</b> \$150 <a href="#">copayment</a> / per drug <b>Mail Order:</b> Not Covered  <b>Prescription cost limitation of \$12,500 per drug/per fill applies. Drugs that cost over \$12,500 per 30 day supply per prescription are excluded from coverage.</b>	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for services. If <a href="#">Preauthorization</a> required but not obtained benefit reduces by 50%.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	None

For more information about limitations and exceptions, contact 1-866-681-1110



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 immediate medical attention	<a href="#">Emergency room care</a>	\$750 <a href="#">copayment</a> after plan <a href="#">deductible</a>		All facilities are covered as in-network subject to meeting “emergency” criteria.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>		All facilities are covered as in-network subject to meeting “emergency” criteria.
	<a href="#">Urgent care</a>	\$75 <a href="#">copayment</a> / per visit	No Charge after <a href="#">deductible</a>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for non-emergency admissions. Failure to obtain pre-certification may result in a reduction in benefit of 50%.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge 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> \$35 <a href="#">copayment</a> / per visit <b>Facility based services:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	Telemedicine via Live Health Online is covered at No Charge after at <a href="#">deductible</a> at <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> or 1-888-548-3432 Coverage includes Primary Care, Specialist Care, and Mental Health & Substance Use.
	Inpatient services	<b>All Facilities:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for non-emergency admissions. Failure to obtain pre-certification may result in a reduction in benefit of 50%.
If you are pregnant	Office visits	<b>Professional Non-Facility based services:</b> \$35 <a href="#">copayment</a> / per visit <b>Facility based services:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge 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 stays longer than 48 hours for vaginal birth or 96 hours for cesarean birth if <a href="#">Preauthorization</a> is not obtained benefit reduces by 50%.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	

For more information about limitations and exceptions, contact 1-866-681-1110



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	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	Maximum <b>120</b> visits per benefit period. Combined In-Network and Out-of-Network limit. Combined limit with Home Infusion. <a href="#">Preauthorization</a> is required or benefit reduces by 50%.
	<a href="#">Rehabilitation services</a>	<b>Professional Non-Facility based services:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	Maximum <b>30</b> 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. <a href="#">Preauthorization</a> is required or benefit reduces by 50%.
		<b>Facility based services:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>		
	<a href="#">Habilitation services</a>	<b>Professional Non-Facility based services:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	Maximum <b>30</b> 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. <a href="#">Preauthorization</a> is required or benefit reduces by 50%.
		<b>Facility based services:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>		
<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	Maximum <b>120</b> days per benefit period. Combined In-Network and Out-of-Network limit. Limit combined with Physical Medical Rehabilitation. <a href="#">Preauthorization</a> is required or benefit reduces by 50%.	
<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for items. If <a href="#">Preauthorization</a> required but not obtained benefit reduces by 50%.	



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)	
	<a href="#">Hospice services</a>	<b>Home Setting:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>  <b>Facility Setting:</b> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	No Charge after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required or benefit reduces by 50%.
<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.
	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>• Abortion - elective</li> <li>• Alternative Medicine</li> <li>• Bariatric Surgery</li> <li>• Biofeedback</li> <li>• Cosmetic Surgery</li> <li>• Custodial Care</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Gene/Cellular Therapy</li> <li>• Growth Hormone Therapy</li> <li>• Infertility Services (Comprehensive (AI) &amp; Advanced (ZIFT/GIFT/IVF)</li> <li>• Long-term Care</li> <li>• Maternity Care for a Dependent Child</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Respite Care</li> <li>• Routine eye care (Adult) and Child except ACA allowed</li> <li>• Routine Foot Care (non-diabetic/metabolic disease)</li> <li>• Sterilization Reversals</li> <li>• TMJ Treatment and Appliances</li> <li>• Vision Exams (Routine) and Hardware</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.)		
<ul style="list-style-type: none"> <li>• Acupuncture - Limited to 15 visits per Benefit period</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care - Limited to 30 visits per Benefit period</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids (Exams/Fittings) – limited to 1 device per ear every 3 years.</li> </ul>

For more information about limitations and exceptions, contact 1-866-681-1110

**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 1-866-681-1110. 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: 1-866-681-1110.

**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 1-866-681-1110

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-681-1110

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-681-1110

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-681-1110

*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>	\$2,000
■ <a href="#">Specialist copayment</a>	\$70
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

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

Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$2,100
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,160</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>	\$2,000
■ <a href="#">Specialist copayment</a>	\$70
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

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

Cost Sharing	
Deductibles*	\$2,000
Copayments	\$400
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,920</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>	\$2,000
■ <a href="#">Specialist copayment</a>	\$70
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

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

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

Cost Sharing	
Deductibles*	\$2,000
Copayments	\$200
Coinsurance	\$90
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,290</b>