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, 1-800-522-0456. 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.associated-admin.com or call 1-800-522-0456 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-Network**: $100/person; $200/family, **Out-of-Network**: $500/person; $1,000/family, per calendar year	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay.
Are there services covered before you meet your deductible?	Yes **In-Network Preventive** care	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?	**In-Network**: Medical: $1,100/person; $2,200/family. Rx: $400/person; $800/family. **Out-of-Network**: Medical: $2,900/person; $5,900/family. Rx: $1,100/person; $2,100/family	The **out-of-pocket limit** is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	**Copayment** on certain services, **premiums**, **balance-billing** charges, 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. See www.anthem.com or call 1-800-810-BLUE for a list of **network 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**. 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**.

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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
		In-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	$20 **copayment**	30% **coinsurance** of **UCR**, then 100% **coinsurance.**	None
	Specialist visit	$40 **copayment**	30% **coinsurance** of **UCR**, then 100% **coinsurance.**	None
	Preventive care/screening/ immunization	No charge. **Deductible** does not apply	30% **coinsurance** of **UCR**, then 100% **coinsurance.**	None
If you have a test	Diagnostic test (x-ray, blood work)	20% **coinsurance**	30% **coinsurance** of **UCR**, then 100% **coinsurance.**	None
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	30% **coinsurance** of **UCR**, then 100% **coinsurance.**	**Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Express-Scripts.com	Generic drugs	Retail: 20% up to $10; Mail: 20% up to $20	Same as **In-network**, plus balance billing.	Retail limited to 34-day supply; mail order limited to 90 day supply. If you can obtain a brand name medication when a generic equivalent is available, you pay the generic **coinsurance** plus the difference between the cost of the brand name drug and the generic. Utilization Management Program in effect. **Preauthorization** required for some drugs. Failure to do so may result in a denial of benefits. For more information contact Express Scripts at 1-877-861-8145
	Preferred brand drugs	Retail: 20% up to $25; Mail: 20% up to $50	Same as **In-network**, plus **balance billing.**	
	Non-preferred brand drugs	Retail: 20% up to $50; Mail: 20% up to $100	Same as **In-network**, plus **balance billing.**	
	Specialty drugs	Retail: 20% up to $50; Mail: 20% up to $100	Same as **In-network**, plus **balance billing.**	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance**	Not covered	**Preauthorization** required for certain services. Failure may result in a denial or penalty of 50% up to $500
	Physician/surgeon fees	20% **coinsurance**	30% **coinsurance** of **UCR**, then 100% **coinsurance**	
If you need immediate medical attention	Emergency room care	$100 **copayment**	$100 copayment and balance between charge and **In-network rate.**	**Copayment** waived if admitted. Limited to initial visit for **Emergency Medical Conditions** as defined by the Summary Plan Description
	Emergency medical transportation	20% **coinsurance**	20% **coinsurance** up to **allowed amount**, then 100% **coinsurance**	If air ambulance, medical condition must warrant air ambulance services
	Urgent care	$20 **copayment**	30% **coinsurance** of **UCR**, then 100% **coinsurance**	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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)	20% **coinsurance**	Not covered except in emergencies. Emergency: 20% **coinsurance** up to **UCR** rate, then 100% **coinsurance**	**Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500. Semi-private room and board allowed only
	Physician/surgeon fees	20% **coinsurance**	30% **coinsurance** of **UCR**, then 100% **coinsurance**	**Preauthorization** required for certain services. Failure may result in a denial or penalty of 50% up to $500
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 **copayment**	30% **coinsurance** of **UCR**, then 100% **coinsurance**	None
	Inpatient services	20% **coinsurance**	30% **coinsurance** of **UCR** rate, then 100% **coinsurance**	**Out-of Network:** coverage for Substance Abuse only. **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500. Semi-private room and board allowed only
If you are pregnant	Office visits	$20 **copayment**	30% **coinsurance** of **UCR**, then 100% **coinsurance**	Cost sharing does not apply to certain **preventive services**. Depending on the type of service, **coinsurance** may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	20% **coinsurance**	30% **coinsurance** of **UCR**, then 100% **coinsurance**	None
	Childbirth/delivery facility services	20% **coinsurance**	Not covered	**Preauthorization** should be obtained within first 3 months of pregnancy, but not required
If you need help recovering or have other special health needs	Home health care	20% **coinsurance**	30% **coinsurance** of **UCR**, then 100% **coinsurance**	In-Network – 200 visits/year. Out-of-Network – 40 visits/year. **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500
	Rehabilitation services	20% **coinsurance**	30% **coinsurance** of **UCR**, then 100% **coinsurance**	30 visits/year for each service. Includes physical, speech, occupational and orthoptic therapies. **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500
	Habilitation services	20% **coinsurance**	30% **coinsurance** of **UCR**, then 100% **coinsurance**	
	Skilled nursing care	20% **coinsurance**	Not covered	60 days/year. **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500
	Durable medical equipment	20% **coinsurance**	30% **coinsurance** of **UCR**, then 100% **coinsurance**	**Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500
	Hospice services	20% **coinsurance**	Not covered	210 days per lifetime. **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam Children's glasses Children's dental check-up	See the Plan's vision/dental Fee Schedule to find your cost for specific services	See the Plan's vision/dental Fee Schedule to find your cost for specific services	None

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.)

- Cosmetic Surgery
- Hearing Aids
- Infertility Treatment
- Long-term care
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)

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-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 the **plan** at 1-800-522-0456. You may also contact 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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-522-0456 Ext. 1336

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.associated-admin.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	$100
Specialist *[copayment]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$20
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,730**

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

The plan's overall deductible	$100
Specialist *[copayment]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$700
Coinsurance	$200
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,200**

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

The plan's overall deductible	$100
Specialist *[copayment]*	$40
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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