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. If you have other family members on the plan, the overall **deductible** must be met before the 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. If you have other family members on the plan, the overall family **out-of-pocket limit** must be met before the plan begins to pay.
What is not included in the out-of-pocket limit?	**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**, 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. **Balance billing** does not apply to services protected by the Federal "No Surprises Act".

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
		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**, plus **balance billing**, where applicable.	Telephonic and video physician visits are covered through Anthem LiveHealth OnLine only. **Copayment** does not apply.
	Specialist visit	$40 **copayment**	30% **coinsurance** of **UCR**, plus **balance billing**, where applicable.	
	Preventive care/screening/ immunization	No charge. **Deductible** does not apply	30% **coinsurance** of **UCR**, plus **balance billing**, where applicable.	None
If you have a test	Diagnostic test (x-ray, blood work)	20% **coinsurance**	30% **coinsurance** of **UCR**, plus **balance billing**, where applicable.	None
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	30% **coinsurance** of **UCR**, plus **balance billing**, where applicable.	**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 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**, where applicable.	Retail limited to 34-day supply; mail order limited to 90-day supply. You may 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, Inc. at 1-877-861-8145. Specialty drugs must be filled through Accredo, an Express Scripts, Inc. specialty pharmacy. For more information regarding the SaveOnSP program, please contact SaveOnSP at 1-800-683-1074 or the UFCW Local 1500 Welfare Fund at (516) 214-1337/(516) 214-1336.
	Preferred brand drugs	Retail: 20% up to $25; Mail: 20% up to $50	Same as **In-network**, plus **balance billing**, where applicable.	
	Non-preferred brand drugs	Retail: 20% up to $50; Mail: 20% up to $100	Same as **In-network**, plus **balance billing**, where applicable.	
	Specialty drugs	Same as non-preferred brand drugs. Drugs covered under SaveOnSP: Enrolled in program: No charge. Not enrolled in program: 30% **coinsurance**	Not covered	
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**, plus **balance billing**, where applicable.	
If you need immediate medical attention	Emergency room care	$100 **copayment**	$100 **copayment**	**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**, **balance billing** where applicable.	If air ambulance, medical condition must warrant air ambulance services. **Out-of-network** air ambulance is paid the same as **In-network**.

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)	
	Urgent care	$20 **copayment**	30% **coinsurance** of **UCR**, plus **balance billing**, where applicable.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance**	Not covered except in emergencies. Emergency: 20% **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**, plus **balance billing**, where applicable. Emergency: 20% **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**, plus **balance billing**, where applicable.	Telephonic and video physician visits are covered for behavioral health only. **Copayment** does not apply to Anthem LiveHealth OnLine visits only.
	Inpatient services	20% **coinsurance**	Mental health, behavioral health services: Not covered Substance abuse services: 30% **coinsurance** of **UCR**, plus **balance billing**, where applicable. Emergency: 20% **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**, plus **balance billing**, where applicable.	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**, plus **balance billing**, where applicable. Emergency: 20% **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)	
	Childbirth/delivery facility services	20% **coinsurance**	Not covered. Emergency: 20% **coinsurance**	**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**, plus **balance billing**, where applicable.	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**, plus **balance billing**, where applicable.	30 visits/year for both In and Out-of-Network services combined for each therapeutic category inclusive of 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**, plus **balance billing**, where applicable.	
	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**, plus **balance billing**, where applicable.	**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.
If your child needs dental or eye care	Children's eye exam	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
	Children's glasses			
	Children's dental check-up			

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	• Infertility Treatment	• Routine foot care
• Hearing Aids	• Long-term 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 (if prescribed for rehabilitation purposes) • Bariatric Surgery	• Chiropractic care • Dental care (Adult)	• Non-emergency care when traveling outside the U.S. • Private-duty nursing (Out-of-Network Only) • 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.
Minimum Essential Coverage for a month, plans, health insurance available through the Marketplace or other individual market 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 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.

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	$100
Copayments	$10
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,110**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	**$840**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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