



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, visit anthembluecross.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.healthcare.gov/sbc-glossary/ or call (800) 553-9603 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<u>In-Network</u> : \$750 Individual / \$1,500 Family <u>Out-of-Network</u> : \$5,000 Individual / \$12,500 Family; <u>Deductible</u> accumulates on a calendar year basis.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive Care</u> , optical and <u>prescription drugs</u> are covered before you meet your overall <u>deductible</u> .	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	Yes. \$50 Individual / \$100 Family for <u>prescription drugs</u> . <u>Deductible</u> accumulates on a calendar year basis. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this plan ?	<u>In-Network</u> Medical and Hospital providers: \$5,350/person or \$10,700/family; <u>out-of-pocket limit</u> accumulates on a calendar year basis. <u>Out-of-Network</u> Medical and Hospital providers: None <u>In-Network Prescription Drugs</u> : \$1,300 Individual / \$2,600 Family; <u>out-of-pocket limit</u> accumulates on a calendar year basis. For <u>Out-of-Network Prescription Drugs</u> : Not Applicable.	<u>In-Network</u> : The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. <u>Out-of-Network</u> : This plan does not have an <u>out-of-pocket limit</u> on your <u>Out-of-Network</u> expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Medical and Hospital: <u>Premiums</u> , <u>balance-billing</u> charges, outpatient <u>prescription drugs</u> , vision, and health care this plan doesn't cover. <u>Prescription Drugs</u> : <u>Premiums</u> , <u>balance-billing</u> charges, medical and hospital expenses, vision care expenses, your <u>cost sharing</u> and costs paid by drug manufacturers for certain non-essential <u>specialty drugs</u> , drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Will you pay less if you use a <u>network provider</u>?	Yes, PPO. See http://www.anthembluecross.com or call (800) 553-9603 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$75 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	In-network <u>specialist</u> visit at an outpatient facility subject to 30% <u>coinsurance</u> .
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	No charge; <u>deductible</u> does not apply	Subject to age and frequency limits. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. *See "Your Hospital and Medical Benefits" section of the SPD and subsequent SMMs.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Diagnostic tests/imaging covered by the office visit will not be subject to coinsurance.
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.expressscripts.com .	Generic drugs	Retail: \$20 <u>copay</u> /prescription Mail Order: \$40 <u>copay</u> /prescription	Retail: \$20 <u>copay</u> /prescription plus difference in cost between <u>Out-of-Network</u> pharmacy charges and <u>allowed amount</u> ; Mail Order: Not covered	Medical <u>deductibles</u> do not apply; separate <u>prescription drug deductible</u> applies. <u>Prescription drug</u> benefit covers up to a 30-day supply for retail prescriptions and up to a 90-day supply for mail order prescriptions. Maintenance <u>prescription drugs</u> are limited to two retail fills and then must be filled through the mail order pharmacy.
	<u>Formulary</u> brand drugs	Retail: \$35 <u>copay</u> /prescription Mail Order: \$70 <u>copay</u> /prescription	Retail: \$35 <u>copay</u> /prescription plus difference in cost between <u>Out-of-</u>	No charge for FDA-approved generic preventive medications and contraceptives (or brand name if a generic is medically inappropriate).

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
			<u>Network</u> pharmacy charges and <u>allowed amount</u> Mail Order: Not covered	Generic drugs are mandatory when available. If you fill a brand name drug when a generic equivalent is available, you will pay an additional amount equal to the difference between the <u>allowed amount</u> for the brand name and the generic medication. If you fill a prescription at an <u>Out-of-Network</u> pharmacy, you will pay an additional amount equal to the difference between the pharmacy's charges and the <u>allowed amount</u> for the medication. Mail order not covered <u>Out-of-Network</u>. Certain drugs are subject to clinical management programs, including <u>formulary</u> management, <u>preauthorization</u>, and/or step therapy criteria in order to be covered and/or there may be quantity limitations or exclusions. Non-<u>formulary</u> brand drugs are excluded and you must pay 100% of this cost, even <u>In-Network</u>. *See the <u>Prescription Drug</u> section of the SPD and SMMs. Drugs administered in a doctor's office or compounded for IV infusion are not available by mail order. <u>Specialty drugs</u> must be ordered from Accredo mail order pharmacy. The SaveOnSP <u>Specialty Drug</u> List is available at www.saveonsp.com/local802afm. Your <u>cost sharing</u> for “non-essential” <u>specialty drugs</u>, as well as any amount paid by the drug manufacturer through its <u>copay</u> assistance program, do not count toward your <u>out-of-pocket limit</u>.
	Non- <u>formulary</u> brand drugs	Not covered (retail and mail order)	Not covered (retail and mail order)	
	<u>Specialty drugs</u>	Retail: Not covered Mail Order: 40% <u>coinsurance</u> (\$300 maximum/prescription) No cost for <u>specialty drugs</u> on the SaveOnSP <u>Specialty Drug</u> List if you enroll in that program. You pay the full <u>copay</u> indicated on that list if you do not enroll in that program.	Not covered (retail and)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required for elective admissions. Admission notification is required within 2 days or when reasonable following emergency admission. If you don't get <u>preauthorization</u> , benefits could be reduced. *See “Your Hospital and Medical Benefits” section of the SPD and subsequent SMMs.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit; <u>deductible</u> does not apply	Covered as In- <u>Network</u>	<u>Copay</u> waived if admitted to the hospital. Professional/physician charges may be billed separately, except as provided by the No Surprises Act.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				When required by law, <u>Out-of-Network emergency room care</u> will be treated as <u>In-Network</u> .
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	Covered as <u>In-Network</u>	Non-emergency <u>Out-of-Network</u> ambulance services covered at 50% <u>coinsurance</u> . When required by law, <u>Out-of-Network</u> air ambulance services will be treated as <u>In-Network</u>
	<u>Urgent care</u>	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	When required by law, <u>Out-of-Network emergency services</u> provided at <u>urgent care</u> facilities licensed in the state to provide emergency care will be treated as <u>In-Network</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 <u>copay</u> /admission; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Preauthorization</u> is required for elective admissions. Admission notification is required within 2 days or when reasonable following emergency admission. If you don't get <u>preauthorization</u> , benefits could be reduced. *See "Your Hospital and Medical Benefits" section of the SPD and subsequent SMMs.
	Physician/surgeon fees	<u>Primary care physician</u> : \$30 <u>copay</u> /visit; <u>Specialist</u> : \$50 <u>copay</u> /visit; <u>Surgeon</u> : 30% <u>coinsurance</u>	50% <u>coinsurance</u>	When required by law, <u>Out-of-Network</u> physician fees will be treated as <u>In-Network</u> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: \$30 <u>copay</u> /visit; <u>deductible</u> does not apply Other outpatient services (partial <u>hospitalization</u> /intensive outpatient): 30% <u>coinsurance</u>	50% <u>coinsurance</u>	Office Visit: Apply one <u>copay</u> per ongoing treatment. Virtual visits (Telehealth) benefits available. Other Outpatient: Apply one <u>copay</u> per ongoing treatment. <u>Preauthorization</u> is required for partial <u>hospitalization</u> and intensive outpatient programs. If you don't get <u>preauthorization</u> , benefits could be reduced. *See "Your Hospital and Medical Benefits" section of the SPD and subsequent SMMs.
	Inpatient services	\$500 <u>copay</u> /admission; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Preauthorization</u> is required for elective admissions. Admission notification is required within 2 days or when reasonable following emergency admission. If you don't get <u>preauthorization</u> , benefits could be reduced. *See "Your Hospital and Medical Benefits" section of the SPD and subsequent SMMs.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>In-Network preventive services</u>. Depending on the type of services and/or <u>provider</u>, a <u>copayment</u>, <u>coinsurance</u>, or <u>deductible</u> may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). *See “Your Hospital and Medical Benefits” section of the SPD and subsequent SMMs. Notification is required for <u>Out-of-Network</u> admissions that exceed 48-hours for delivery (or 96-hours for C-sections).
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$500 <u>copay</u> /admission; <u>deductible</u> does not apply	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 40 visits/calendar year (combined <u>In/Out-of-Network</u>).
	<u>Rehabilitation services</u>	Office visit: \$50 <u>copay</u> /visit; <u>deductible</u> does not apply Outpatient facility services: 30% <u>coinsurance</u> Inpatient: \$500 <u>copay</u> /admission; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Preauthorization</u> is required for elective admissions. Admission notification is required within 2 days or when reasonable following emergency admission. If you don't get <u>preauthorization</u> , benefits could be reduced. *See “Your Hospital and Medical Benefits” section of the SPD and subsequent SMMs. Outpatient maintenance speech and hearing therapy not covered.
	<u>Habilitation services</u>	Inpatient and outpatient: 30% <u>coinsurance</u>	Inpatient and outpatient: 50% <u>coinsurance</u>	Outpatient maintenance speech and hearing therapy not covered.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 60 <u>skilled nursing care</u> facility bed days/calendar year (combined <u>In/Out-of-Network</u>). <u>Preauthorization</u> is required for elective admissions. Admission notification is required within 2 days or when reasonable following emergency admission. If you don't get <u>preauthorization</u> , benefits could be reduced. *See “Your Hospital and Medical Benefits” section of the SPD and subsequent SMMs.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Hospice services</u>	Inpatient and outpatient: 30% <u>coinsurance</u>	Inpatient and outpatient: 50% <u>coinsurance</u>	Inpatient hospice coverage is limited to 210 days/lifetime.
If your child needs dental or eye care	Children's eye exam	Amount over \$15 <u>plan</u> allowance	Amount over \$15 <u>plan</u> allowance	Medical <u>deductibles</u> do not apply. Does not count toward <u>out-of-pocket limit</u>. Vision benefits separately administered by General Vision Services and Vision Screening. Coverage limited to one eye exam/calendar
	Children's glasses	Frames: Amount over \$11 <u>plan</u> allowance;	Frames: Amount over \$11 <u>plan</u> allowance; Single	

* For more information about limitations and exceptions, see [plan](#) or policy document at anthembluecross.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
		Single vision lenses: Amount over \$13 <u>plan</u> allowance; Bifocals: Amount over \$19 <u>plan</u> allowance; Trifocals: Amount over \$24 <u>plan</u> allowance	vision lenses: Amount over \$13 <u>plan</u> allowance; Bifocals: Amount over \$19 <u>plan</u> allowance; Trifocals: Amount over \$24 <u>plan</u> allowance	year and one complete pair of glasses/calendar year. You are responsible for amounts over <u>plan</u> allowances.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses, even <u>In-Network</u>

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
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs (Except for morbid obesity and as required for preventive services under the ACA)

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

- Acupuncture (Combined 50-visit limit/calendar year with chiropractic care and physical therapy)
- Bariatric Surgery
- Chiropractic care (Combined 50-visit limit/calendar year with acupuncture and physical therapy)
- Infertility treatment (Limited to diagnosis and treatment of correctable medical conditions that result in infertility)
- Routine eye care (Adult) (Limited to one eye exam/calendar year and one pair of glasses/calendar year)

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: New York State Department of Financial Services, One State Street, New York, NY 10004-1511, (800) 342-3736, (212) 480-6400, (518) 474-6600, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov. 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 on how 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:

ATTN: Grievances and Appeals, Mail Drop R/6-O, P.O. Box 11825, Albany, NY 12211

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

Community Service Society of New York, Community Health Advocates, 105 East 22nd Street, 8th floor, New York, NY 10010, (888) 614-5400, www.communityhealthadvocates.org, cha@cssny.org

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes 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.

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall <u>deductible</u>	\$750	■ The <u>plan's</u> overall <u>deductible</u>	\$750	■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist copayment</u>	\$75	■ <u>Specialist copayment</u>	\$75	■ <u>Specialist copayment</u>	\$75
■ Hospital (facility) <u>copayment</u>	\$500	■ Hospital (facility) <u>copayment</u>	\$500	■ Hospital (facility) <u>copayment</u>	\$500
■ Other <u>coinsurance</u>	30%	■ Other <u>coinsurance</u>	30%	■ Other <u>coinsurance</u>	30%
This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)		This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)		This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)	
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<u>Cost Sharing</u>		<u>Cost Sharing</u>		<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$800	<u>Deductibles*</u>	\$800	<u>Deductibles*</u>	\$760
<u>Copayments</u>	\$510	<u>Copayments</u>	\$1,020	<u>Copayments</u>	\$670
<u>Coinsurance</u>	\$1,000	<u>Coinsurance</u>	\$50	<u>Coinsurance</u>	\$280
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$20	Limits or exclusions	\$0	Limits or exclusions	\$0
The total Peg would pay is	\$2,330	The total Joe would pay is	\$1,870	The total Mia would pay is	\$1,710

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

***NOTE:** This plan has other deductibles for specific services included in this coverage example.
See "Are there other deductibles for specific services?" row above.