



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 1-844-864-5011. 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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-844-864-5011 to request a copy. **For assistance with claims and medical benefits, contact LEA member Services Concierge at 1-844-864-5011.**

Important Questions	Answers	Why This Matters:
<a href="#">What is the overall deductible?</a>	<p><a href="#">Network providers:</a>  \$3,500 Individual / \$7,000 Family</p> <p><a href="#">Out-of-network providers:</a>  \$6,000 Individual / \$12,000 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).
<a href="#">Are there services covered before you meet your deductible?</a>	Yes. <a href="#">Prescription drugs</a> , <a href="#">Preventive care</a> , Primary care services, 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> .
<a href="#">Are there other <u>deductibles</u> for specific services?</a>	No.	You don't have to meet <a href="#">deductible</a> for specific services.
<a href="#">What is the <u>out-of-pocket limit</u> for this <a href="#">plan</a>?</a>	<p><a href="#">Network providers:</a>  \$6,000 Individual / \$12,000 Family</p> <p><a href="#">Out-of-network providers:</a>  \$10,000 Individual / \$20,000 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).
<a href="#">What is not included in the <u>out-of-pocket limit</u>?</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> .
<a href="#">Will you pay less if you use a <a href="#">network provider</a>?</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.
<a href="#">Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</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> \$25 <a href="#">copay</a> /per visit  <b>Facility based services:</b> \$25 <a href="#">copay</a> /per visit <i>Savings Plus Plan Benefit</i>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	<a href="#">Specialist</a> visit to treat an injury or illness	<b>Professional Non-Facility based services:</b> \$50 <a href="#">copay</a> /per visit  <b>Facility based services:</b> \$50 <a href="#">copay</a> /per visit <i>Savings Plus Plan Benefit</i>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	<a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a>	No Charge	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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 preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<b>Lab &amp; Pathology &amp; Radiology: Office or Independent Lab:</b> \$25 <a href="#">copay</a> /per visit  <b>Lab &amp; Pathology &amp; Radiology: Facility based services:</b> 15% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
	Imaging (CT/PET scans, MRIs)	<b>Office or Independent Lab:</b> 15% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Sleep Studies are covered in the home at Office or Independent Lab Cost Share.  <a href="#">Preauthorization</a> is required or benefit reduces by 20%.
		<b>Facility based services:</b> 15% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>		



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.carelonrx.com">www.carelonrx.com</a> or call 1-833-261-2460	Generic drugs (Tier 1)	<b>30 day supply:</b> Lesser of cost of medication or \$10 <a href="#">copay</a> <b>31-90 day supply:</b> Lesser of cost of medication or \$25 <a href="#">copay</a>	Not Covered	Covers 30 day supply (retail), 31-90 day supply (retail or mail order).  Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage.  <b>No Charge for ACA mandated generic medications.</b>
	Preferred brand drugs (Tier 2)	<b>30 day supply:</b> \$25 copay (Deductible waived) <b>31-90 day supply:</b> \$50 copay (Deductible waived)	Not Covered	
	Non-preferred brand drugs (Tier 3)	<b>30 day supply:</b> \$50 copay (Deductible waived) <b>31-90 day supply:</b> \$125 copay (Deductible waived)	Not Covered	
	<a href="#">Specialty drugs</a> (Tier 4)	All Specialty Drugs are Excluded: Contact Payer Matrix for assistance at 1-877-305-6202 9am - 8pm EST M-F.	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required for some services. If <a href="#">Preauthorization</a> required but not obtained benefit reduces by 20%.
	Physician/surgeon fees	15% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> /per visit <a href="#">deductible</a> waived <i>Savings Plus Plan Benefit</i>		ER <a href="#">copay</a> is waived if admitted as inpatient. All facilities are covered as in-network subject to meeting "emergency" criteria.
	<a href="#">Emergency medical transportation</a>	15% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>		All facilities are covered as in-network subject to meeting "emergency" criteria.
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /per visit <a href="#">deductible</a> Waived	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	15% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	<a href="#">Preauthorization</a> is required or benefit reduces by \$1,000.
	Physician/surgeon fees	15% <a href="#">coinsurance</a> after <a href="#">deductible</a> <i>Savings Plus Plan Benefit</i>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None.



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 mental health, behavioral health, or substance abuse services	Outpatient services	<b>Professional Non-Facility based services:</b> \$25 <u>copay</u> /per visit <b>Facility based services:</b> \$25 <u>copay</u> /per visit <i>Savings Plus Plan Benefit</i>	30% <u>coinsurance</u> after <u>deductible</u>	<u>Preadmission</u> is required or benefit reduces by 20% for Applied Behavioral Analysis, Intensive Outpatient Program, and Partial Hospitalization
	Inpatient services	15% <u>coinsurance</u> after <u>deductible</u> <i>Savings Plus Plan Benefit</i>	30% <u>coinsurance</u> after <u>deductible</u>	<u>Preadmission</u> is required or benefit reduces by \$1,000.
If you are pregnant	Office visits	<b>Professional Non-Facility based services:</b> No charge <b>Facility based services:</b> No charge <i>Savings Plus Plan Benefit</i>	30% <u>coinsurance</u> after <u>deductible</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <b>Maternity Care for a Dependent Child is not covered.</b> <u>Preadmission</u> is required for stays longer than 48 hours for vaginal birth or 96 hours for cesarean birth if <u>Preadmission</u> is not obtained benefit reduces by \$1,000.
		Childbirth/delivery professional services	15% <u>coinsurance</u> after <u>deductible</u> <i>Savings Plus Plan Benefit</i>	30% <u>coinsurance</u> after <u>deductible</u>
	Childbirth/delivery facility services	15% <u>coinsurance</u> after <u>deductible</u> <i>Savings Plus Plan Benefit</i>	30% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>
	Home health care	15% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	Limited to <b>60</b> visits per calendar year. <u>Preadmission</u> is required or benefit reduces by 20%.
If you need help recovering or have other special health needs	Rehabilitation services	<b>Professional Non-Facility based services:</b> \$25 <u>copay</u> /per visit <b>Facility based services:</b> \$25 <u>copay</u> /per visit <i>Savings Plus Plan Benefit</i>	30% <u>coinsurance</u> after <u>deductible</u>	Maximum <b>60</b> visits per calendar year. Combined limit for Rehabilitative / Habilitative services includes physical therapy, speech therapy, and occupational therapy. Combined In-Network and Out-of-Network limit. <u>Preadmission</u> is required or benefit reduces by 20%.



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 your child needs dental or eye care</b>	<u>Habilitation services</u>	<b>Professional Non-Facility based services:</b> \$25 <u>copay</u> /per visit	30% <u>coinsurance</u> after <u>deductible</u>	Maximum <b>60</b> visits per calendar year. Combined limit for Rehabilitative / Habilitative services includes physical therapy, speech therapy, and occupational therapy. Combined In-Network and Out-of-Network limit. <u>Preauthorization</u> is required or benefit reduces by 20%.
		<b>Facility based services:</b> \$25 <u>copay</u> /per visit <i>Savings Plus Plan Benefit</i>		
	<u>Skilled nursing care</u>	15% <u>coinsurance</u> after <u>deductible</u> <i>Savings Plus Plan Benefit</i>	30% <u>coinsurance</u> after <u>deductible</u>	Maximum <b>60</b> days per calendar year. Combined limit with Inpatient Physical Medical Rehabilitation. Combined In-Network and Out-of-Network limit. <u>Preauthorization</u> is required or benefit reduces by \$1,000.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> is required for items. If <u>Preauthorization</u> required but not obtained benefit reduces by 20%.
<b>If your child needs dental or eye care</b>	<u>Hospice services</u>	<b>Home Setting:</b> 15% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> is required or benefit reduces by \$1,000.
		<b>Facility Setting:</b> 15% <u>coinsurance</u> after <u>deductible</u> <i>Savings Plus Plan Benefit</i>		
	<u>Children's eye exam</u>	<b>Professional Non-Facility based services:</b> \$50 <u>copay</u> /per visit	30% <u>coinsurance</u> after <u>deductible</u>	Children eye exam non PPACA limited to 1 exam every 24 months. PPACA mandated service: One vision screening for children 3-5 years is covered as a preventive service. Cost sharing does not apply for preventive services.
	<u>Children's glasses</u>	<b>Facility based services:</b> \$50 <u>copay</u> /per visit <i>Savings Plus Plan Benefit</i>		



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)	
	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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Biofeedback
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Growth Hormone Therapy
- Long-term Care
- Maternity care for dependent child
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- TMJ Treatment and Appliances
- Orthopedic Shoes/inserts- Non-diabetic
- Sterilization Reversals
- Weight Loss programs

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

- Chiropractic Care (Limited 20 visits calendar year).
- Hearing Aids (Limited to 1 device per ear/24 months)
- Respite Care
- Vision Exams (Routine) (Hardware excluded)  
All ages. Limited to 1 exam every 24 months.

**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 1-844-864-5011. 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: 1-844-864-5011.

**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 1-844-864-5011

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-864-5011

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-864-5011

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-844-864-5011

*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>	\$1,000
■ <a href="#">Specialist copayment</a>	\$50
■ <a href="#">Hospital (facility) coinsurance</a>	15%
■ <a href="#">Other coinsurance</a>	15%

#### 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>\$12,687</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$111
Coinsurance	\$1,510

#### What isn't covered

Limits or exclusions	\$61
<b>The total Peg would pay is</b>	<b>\$2,682</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>	\$1,000
■ <a href="#">Specialist copayment</a>	\$50
■ <a href="#">Hospital (facility) coinsurance</a>	15%
■ <a href="#">Other coinsurance</a>	15%

#### 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>\$5,601</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$790
Copayments	\$827
Coinsurance	\$0

#### What isn't covered

Limits or exclusions	\$22
<b>The total Joe would pay is</b>	<b>\$1,639</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>	\$1,000
■ <a href="#">Specialist copayment</a>	\$50
■ <a href="#">Hospital (facility) coinsurance</a>	15%
■ <a href="#">Other coinsurance</a>	15%

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

Cost Sharing	
Deductibles*	\$1,000
Copayments	\$530
Coinsurance	\$93

#### What isn't covered

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,623</b>