
 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, 1-855-550-1696. 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.ubcbenefits.org](http://www.ubcbenefits.org) or call 1-855-550-1696 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$50/person.</b> Doesn't apply to preventive care or emergency care resulting from accidental injury	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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, preventative or emergency care resulting from accidental injury	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 must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$1,050/person</b> for participating and non-participating providers. For prescription drugs: <b>\$6,550/person and \$13,100/family</b>	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> .
What is not included in the <a href="#">out-of-pocket limit</a> ?	Balance-billed charges, fixed dollar copayments and health care this plan 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. See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-810-2583 for a list of participating providers.	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 don't need a referral to see a specialist.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services.

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$5 copay/visit	20% coinsurance and expenses above the allowable charge	_____none_____
	<a href="#">Specialist</a> visit	\$5 copay/visit	20% coinsurance and expenses above the allowable charge	_____none_____
	<a href="#">Preventive care/screening/immunization</a>	\$5 copay/visit	20% coinsurance and expenses above the allowable charge	COVID-19 vaccinations and diagnostic tests and related services are covered without cost sharing (including on an out-of-network basis). Plan to cover up to six (6) tests per year without being ordered by doctor
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	20% coinsurance and expenses above the allowable charge	_____none_____
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance and expenses above the allowable charge	
<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.express-scripts.com">www.express-scripts.com</a> or by calling 800-718-5910	Generic drugs (Tier 1)	Retail: \$5 copay / prescription Mail Order: \$12 copay / prescription		Retail pharmacies will provide up to a 34-day supply, or 100-unit doses if greater, per prescription. Mail Order pharmacy will provide up to a 90-day supply per prescription. <b>Note:</b> If drugs are purchased at a non-participating pharmacy, you pay 100% at time of purchase and apply for reimbursement from Express Scripts. Specialty medications must be ordered through Accredo at 1-800-803-2523 or at <a href="http://www.accredo.com">www.accredo.com</a> . If prior authorization is needed, you may be directed back to Express Scripts for the authorization. Specialty drugs are only available by Mail Order. Covers up to a 30-day supply.
	Preferred brand drugs (Tier 2)	Retail: \$10 copay / prescription Mail Order: \$25 copay / prescription		
	Non-preferred brand drugs (Tier 3)	Retail: \$15 copay / prescription, Mail Order: \$38 copay / prescription		
	<a href="#">Specialty drugs</a> (Tier 4)	Generic \$12 copay / prescription Preferred Brand: \$25 copay / prescription Non-preferred brand: \$38 copay / prescription		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance and expenses above the allowable charge	_____none_____

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No Charge	20% coinsurance and expenses above the allowable charge	—————none—————
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	No Charge	No Charge	Deductible does not apply to emergency services, however non-emergency treatment or treatment for <i>illness</i> received in the emergency room is subject to the \$50 deductible and 20% coinsurance
	<a href="#">Emergency medical transportation</a>	No Charge	20% coinsurance and expenses above the allowable charge	If a network ambulance is unavailable the Plan pays for out-of-network ambulance at same rate as a network ambulance service in the locality where the charge is incurred.
	<a href="#">Urgent care</a>	\$5 copay/visit or No Charge	20% coinsurance and expenses above the allowable charge	Payment is based on the type of facility that bills the service. Copay applies when urgent care services are billed by a physician's office. Urgent care available in other settings for no charge.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No Charge	20% coinsurance and expenses above the allowable charge	Payment for hospitalization expenses (other than for emergency or urgent care) are reduced by 25% if not pre-authorized. Call Hines & Associates at 1-847-741-1291
	Physician/surgeon fees	No Charge	20% coinsurance and expenses above the allowable charge	Out-of-network providers may not balance bill for treatment at a network facility unless you give consent. See the announcement dated December 2021 regarding protections from surprise medical bills.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visit: \$5 copay. Other outpatient services: No Charge	20% coinsurance and expenses above the allowable charge	—————none—————
	Inpatient services	No Charge	20% coinsurance and expenses above the allowable charge	
<b>If you are pregnant</b>	Office visits	No Charge	20% coinsurance and expenses above the allowable charge	Not covered for dependent children except for complication of pregnancy, even in-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	No Charge	20% <a href="#">coinsurance</a> and expenses above the allowable charge	
	Childbirth/delivery facility services	No Charge	20% coinsurance and expenses above the allowable charge	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No Charge	20% coinsurance	Limited to 40 visits per year.
	<a href="#">Rehabilitation services</a>	No Charge	20% coinsurance and expenses above the allowable charge	—————none—————
	<a href="#">Habilitation services</a>	No Charge	20% coinsurance and expenses above the allowable charge	—————none—————
	<a href="#">Skilled nursing care</a>	No Charge	20% coinsurance and expenses above the allowable charge	Limited to 90 days per confinement.
	<a href="#">Durable medical equipment</a>	No Charge	20% coinsurance and expenses above the allowable charge	—————none—————
	<a href="#">Hospice services</a>	No Charge	20% coinsurance and expenses above the allowable charge	—————none—————
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	No Charge	Children under age 19 may receive one eye exam and one pair of glasses per year. \$350 plan allowance per year.
	Children's glasses	No Charge	No Charge	
	Children's dental check-up	No Charge	No Charge	Limited to \$2,500 combined dental maximum per year. Limit does not apply to dental check-ups for children under age 19.

## 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
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Weight loss programs
- Prenatal and postnatal care for dependent children (except for complication of pregnancy)

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

- Acupuncture (Limited to 20 visits per year)
- Transplant Services
- Chiropractic care (Limited to 50 visits per year)
- Dental care (Limited to \$2,500 maximum benefit per year)
- Hearing Aids
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Limited to \$350 for eye exam and glasses combined, once every 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

**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 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 855-550-1696.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-550-1696.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 855-550-1696.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 855-550-1696.

—————*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](#) \$50
- [Specialist copayment](#) \$5
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

**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>\$12,570</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$50
Copayments	\$20
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$130</b>

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

- The [plan's](#) overall [deductible](#) \$50
- [Specialist copayment](#) \$5
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

**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>\$5,330</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$50
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$270</b>

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

- The [plan's](#) overall [deductible](#) \$50
- [Specialist copayment](#) \$5
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

**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>\$2,730</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles*	\$50
Copayments	\$20
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$70</b>