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 or call 1-855-550-1696 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$50**/person. 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 deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible.
Are there services covered before you meet your deductible?	Yes, preventative or emergency care resulting from accidental injury	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$1,050/person** for participating and non-participating providers. For prescription drugs: **$6,550/person and $13,100/family**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits.
What is not included in the out-of-pocket limit?	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 out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.anthem.com or call 1-800-810-2583** for a list of participating 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.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	This plan will pay some or all of the costs to see a specialist 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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay/visit	20% coinsurance and expenses above the allowable charge	——————none——————
	Specialist visit	$5 copay/visit	20% coinsurance and expenses above the allowable charge	——————none——————
	Preventive care/screening/ immunization	$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
If you have a test	Diagnostic test (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	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com 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. **Note:** 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 www.accredo.com. 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		
	Specialty drugs (Tier 4)	Generic $12 copay / prescription Preferred Brand: $25 copay / prescription Non-preferred brand: $38 copay / prescription		
If you have outpatient surgery	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————————
If you need immediate medical attention	Emergency room care	No Charge	No Charge	Deductible does not apply to emergency services, however non-emergency treatment or treatment for *illness* received in the emergency room is subject to the $50 deductible and 20% coinsurance
	Emergency medical transportation	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.
	Urgent care	$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.
If you have a hospital stay	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.
If you need mental health, behavioral health, or substance abuse services	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	
If you are pregnant	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% coinsurance and expenses above the allowable charge	
	Childbirth/delivery facility services	No Charge	20% coinsurance and expenses above the allowable charge	
If you need help recovering or have other special health needs	Home health care	No Charge	20% coinsurance	Limited to 40 visits per year.
	Rehabilitation services	No Charge	20% coinsurance and expenses above the allowable charge	——————none——————
	Habilitation services	No Charge	20% coinsurance and expenses above the allowable charge	
	Skilled nursing care	No Charge	20% coinsurance and expenses above the allowable charge	Limited to 90 days per confinement.
	Durable medical equipment	No Charge	20% coinsurance and expenses above the allowable charge	——————none——————
	Hospice services	No Charge	20% coinsurance and expenses above the allowable charge	——————none——————
If your child needs dental or eye care	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 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, kwiijigo 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)*

Total Example Cost	**$12,570**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$50
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$130**

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)*

Total Example Cost	**$5,330**

In this example, Joe would pay:

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

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)*

Total Example Cost	**$2,730**

In this example, Mia would pay:

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

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