



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, call (914) 737-7220. 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 (914) 737-7220 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For <u>network providers</u> : \$250 individual / \$625 family. <u>Deductible</u> applies for each calendar year (January 1 – December 31)	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , 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 deductible?	Yes. <u>In-network</u> : primary care, <u>specialist</u> office visits, <u>preventive care</u> , <u>emergency/urgent care</u> , <u>home health care</u> , <u>prescription drugs</u> , vision and certain outpatient <u>rehabilitation services</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> 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 <u>plan</u> 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 deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For Medical <u>network providers</u> : \$3,500 individual / \$8,750 family; <u>Prescription drugs</u> : \$3,520 individual / \$8,800 family. <u>Out-of-pocket limits</u> apply for each calendar year (January 1 – December 31)	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 <u>plan</u> , 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.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain <u>preauthorization</u> for services, <u>premiums</u> , <u>balance-billing</u> charges, vision benefits and health care this <u>plan</u> 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 network provider?	Yes. See www.anthem.com , the Sydney™ Health app or call 1-844-241-7089 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 full cost if you use an <u>out-of-network provider</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.

Important Questions	Answers	Why This Matters:
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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or <u>clinic</u>	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /office visit; <u>deductible</u> does not apply	Not covered	Medications administered in office: For <u>network providers</u> : 10% <u>coinsurance</u> after <u>deductible</u> ; For <u>out-of-network providers</u> : Not covered.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply Acupuncture: 10% <u>coinsurance</u> Outpatient hospital: 10% <u>coinsurance</u> Chiropractor: \$40 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	Medications administered in office: For <u>network providers</u> : 10% <u>coinsurance</u> after <u>deductible</u> ; For <u>out-of-network providers</u> : Not covered
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	Not covered	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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> required. Failure to obtain <u>preauthorization</u> may result in a 50% benefit reduction up to \$5,000.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	Not covered	

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.OptumRx.com or by calling (866) 863-1408	Generic drugs	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	20% <u>coinsurance</u> plus amount over Average Wholesale Price; <u>deductible</u> does not apply	The <u>deductible</u> does not apply. Your <u>cost sharing</u> for these benefits counts toward the plan's <u>out-of-pocket limit</u> for <u>prescription drugs</u> . No charge for generic contraceptives or other generic ACA-required preventive drugs (or for brand if the generic is not medically appropriate). Retail: 31-day supply. Mail-order: 90-day supply. Mail-order drugs should be ordered from OptumRx Mail Order. Your <u>provider</u> may fax prescriptions to 1-800-491-7997. For questions, call 1-877-889-6358. <u>Preauthorization</u> is required for some drugs in order to be covered. No coverage for non-formulary drugs. <u>Specialty drugs</u> must be ordered through BriovaRx Pharmacy. Your <u>provider</u> may fax prescriptions to 1-877-342-4596 or they may be sent electronically via escripts. For questions, call 1-855-427-4682.
	Preferred brand drugs	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	20% <u>coinsurance</u> plus amount over Average Wholesale Price; <u>deductible</u> does not apply	
	Non-preferred brand drugs	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	20% <u>coinsurance</u> plus amount over Average Wholesale Price; <u>deductible</u> does not apply	
	<u>Specialty drugs</u>	20% <u>coinsurance</u> ; <u>deductible</u> does not apply No charge for certain generic specialty drugs.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	Not covered	Failure to obtain <u>preauthorization</u> may result in a 50% benefit reduction up to \$5,000.
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit; <u>deductible</u> does not apply	\$200 <u>copay</u> /visit; <u>deductible</u> does not apply	<u>Copay</u> waived if admitted to hospital within 24 hours. Professional/physician charges may be billed separately.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	Not covered	None.
	<u>Urgent care</u>	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	Not covered	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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	Not covered	Failure to obtain <u>preauthorization</u> may result in a 50% benefit reduction up to \$5,000.
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Freestanding facility and outpatient hospital services: 10% <u>coinsurance</u> ; Office visit: \$20 <u>copay</u> /visit, <u>deductible</u> does not apply	Not covered	<u>Preauthorization</u> required for intensive outpatient, partial hospitalization and inpatient hospital services. Failure to obtain <u>preauthorization</u> may result in a 50% benefit reduction up to \$5,000. No <u>preauthorization</u> required for outpatient office visits.
	Inpatient services	10% <u>coinsurance</u>	Not covered	
If you are pregnant	Office visits	10% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> does not apply for <u>in-network preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	Not covered	

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 least)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u> ; <u>deductible</u> doesn't apply	Not covered	Limited to 200 visits per year.
	<u>Rehabilitation services</u>	Outpatient: \$40 <u>copay</u> , <u>deductible</u> does not apply. Inpatient: 10% <u>coinsurance</u>	Not covered	Outpatient: Limited to 30 visits per year Inpatient: Limited to 30 days per year. Failure to obtain <u>preauthorization</u> for all inpatient physical therapy, occupational, and speech therapy admissions may result in a 50% benefit reduction up to \$5,000.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	Not covered	All habilitation visits count toward rehabilitation visit limit.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	Not covered	Limited to 60 days per year. Failure to obtain <u>preauthorization</u> may result in a 50% benefit reduction up to \$5,000.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	Not covered	Failure to obtain <u>preauthorization</u> may result in a 50% benefit reduction up to \$5,000.
	<u>Hospice services</u>	10% <u>coinsurance</u>	Not covered	Limited to 365 days per lifetime; 5 visits for family bereavement counseling.
If your child needs dental or eye care	Children's eye exam	Vision Network: Amount over \$125 <u>Plan</u> allowance (combined with glasses) Vision Resource: \$5 <u>copay</u> .	Amount over \$50 <u>Plan</u> allowance.	Eye exam and lenses limited to once per year. Frames limited to once every two years. Active participants may also get one pair of Safety Glasses per year. Vision Resource: Eye Exam: <u>In-network</u> : \$10 <u>copay</u> for new patients. Lenses: <u>In-network</u> : \$5 <u>copay</u> /bifocals or \$110 <u>copay</u> /progressives
	Children's glasses	Vision Network: Amount over \$125 <u>Plan</u> allowance (combined with eye exam) Vision Resource: Amount over \$100 <u>Plan</u> allowance for frames and \$1 <u>copay</u> /single vision lenses.	Amount over \$100 <u>Plan</u> allowance for frames and amount over \$29 <u>Plan</u> allowance for single vision lenses.	Vision benefits administered separately by Vision Resources and Vision Network. The <u>deductible</u> does not apply. Your <u>cost sharing</u> for these benefits is not included in the <u>plan's out-of-pocket limit</u> . <u>Out-of-Network</u> reimbursement based on Vision Resource schedule.
	Children's dental check-up	Not covered	Not covered	You must pay 100% of these expenses.

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.)

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| • Cosmetic surgery | • Hearing aids | • Routine foot care |
| • Dental care (Adult) | • Private-duty nursing | • Weight loss programs (except as required by the health reform law) |

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

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| • Acupuncture | • Infertility treatment | • Non-emergency care when traveling outside the U.S. |
| • Bariatric surgery | • Long-term care (subject to <u>Plan</u> criteria) | • Routine eye care (Adult & Child) |
| • Chiropractic care | | |

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For more information on your rights to continue coverage, you may also contact the plan at (914) 737-7220. 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 the plan at (914) 737-7220. 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 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-662-5193.

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 in-network self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,230

<i>What isn't covered</i>	
Limits or exclusions	\$60

The total Peg would pay is	\$1,540
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Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$120
<u>Copayments</u>	\$160
<u>Coinsurance</u>	\$860

<i>What isn't covered</i>	
Limits or exclusions	\$250

The total Joe would pay is	\$1,390
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$520
<u>Coinsurance</u>	\$80

<i>What isn't covered</i>	
Limits or exclusions	\$0

The total Mia would pay is	\$850
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The plan would be responsible for the other costs of these EXAMPLE covered services.