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 800-432-2924. 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.cciio.cms.gov or call 800-432-2924 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $400 Individual/$800 Family; Non-Network: $800 Individual/$1600 Family.	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 until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes: physician's office visits, inpatient hospital room and board; pre-operative testing for inpatient and outpatient hospitalization; and second surgical opinions.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: $1,500 Individual/$3,000 Family; Non-Network: $3,000 Individual/$6,000 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 until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments, premiums, deductibles, balance-billed charges, health care this plan doesn't cover, and penalties for failure to pre-certify services and non-emergency ER visits.	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 800-810-2583 for a list of network 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 an out-of-network 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 can see the specialist you choose without a referral.

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	$15 copayment; deductible does not apply.	25% coinsurance plus balance billing.	Surgery performed in a doctor's office is subject to deductible and than 15% network / 25% non-network coinsurance. 10 visits per calendar year limit for spinal subluxation and related services.
	Specialist visit	$15 copayment; deductible does not apply.	25% coinsurance plus balance billing.	
	Preventive care/screening/ immunization	$15 copayment; deductible does not apply.	25% coinsurance plus balance billing.	One per year limit for routine mammograms and PAP smears. Copayment waived for immunizations received without office visit charge. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance.	25% coinsurance plus balance billing.	Pre-operative testing performed on an out-patient basis is covered at no charge and is not subject to the deductible.
	Imaging (CT/PET scans, MRIs)	15% coinsurance.	25% coinsurance plus balance billing.	

[* For more information about limitations and exceptions, see the plan or policy document at www.nwoadm.com or call 800-423-2924.]

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.express-scripts.com or 800-818-6602.	Generic drugs	Retail: $10 copayment.	Mail Order: $20 copayment.	Participants are required to pay for prescriptions at non-participating pharmacies and submit their receipts for reimbursement, less the copayment and 25% coinsurance.	Retail: Max supply limited to 34 days; mail-order mandatory for maintenance meds after 3 refills. Mail-order: Max supply limited to 100 days. Limited to one smoking cessation course of treatment per individual per lifetime. Injectable infertility medication and non-FDA approved compounded drugs not covered.
	Brand drugs	$20 copayment formulary; $30 copayment non-formulary.	$40 copayment formulary; $60 copayment non-formulary.		
	Specialty drugs	Available through Accredo Specialty Pharmacy and under the terms of Accredo's pharmacy management program.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance.		25% coinsurance plus balance billing.	None.
	Physician/surgeon fees	15% coinsurance.		25% coinsurance plus balance billing.	None.
If you need immediate medical attention	Emergency room care	15% coinsurance.		25% coinsurance plus balance billing.	Participant responsible for 50% coinsurance for non-emergency care administered in an ER.
	Emergency medical transportation	15% coinsurance.		25% coinsurance plus balance billing.	Air ambulance only covered if attending physician certifies that ground transport would have been inappropriate.
	Urgent care	15% copayment.		25% coinsurance plus balance billing.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance.		25% coinsurance plus balance billing.	Precertification required, or subject to penalty of 10%, up to $500.
	Physician/surgeon fees	15% coinsurance.		25% coinsurance plus balance billing.	

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 mental health, behavioral health, or substance abuse services	Outpatient services	$15 copayment.	25% coinsurance plus balance billing.	EAP assessment will give access to three free visits.
	Inpatient services	15% coinsurance.	25% coinsurance plus balance billing.	Precertification required, or subject to penalty of 10%, up to $500.
If you are pregnant	Office visits	15% coinsurance.	25% coinsurance plus balance billing.	None.
	Childbirth/delivery professional services	15% coinsurance.	25% coinsurance plus balance billing.	No precertification required for first 48 hours for vaginal delivery or 96 hours after cesarean delivery. No coverage for dependent children.
	Childbirth/delivery facility services	15% coinsurance.	25% coinsurance plus balance billing.	
If you need help recovering or have other special health needs	Home health care	15% coinsurance.	25% coinsurance plus balance billing.	Limited to 120 visits/4 hours per visit, per calendar year. Precertification required.
	Rehabilitation services	15% coinsurance.	25% coinsurance plus balance billing.	For inpatient convalescence, must be admitted within 14 days of hospital inpatient stay. Precertification required. Limited to 20 physical therapy visits per condition.
	Habilitation services	Not covered.	Not covered.	N/A
	Skilled nursing care	15% coinsurance.	25% coinsurance plus balance billing.	Must be admitted within 14 days of hospital inpatient stay. Precertification required.
	Durable medical equipment	15% coinsurance.	25% coinsurance plus balance billing.	None.
	Hospice services	15% coinsurance.	25% coinsurance plus balance billing.	Precertification required. Benefits limited to maximum Medicare reimbursement for geographic area. Requires election in lieu of other plan benefits.
If your child needs dental or eye care	Children's eye exam	$15 copayment.	Maximum benefit of $35.	One exam per person, per year.
	Children's glasses	$25 copayment each for frames and lenses.	Maximum benefit of $70-125, depending on type of lenses required.	One pair of glasses allowed every two years. Contacts available for $25 copayment if medically necessary; elective contacts maximum benefit of $105 every two years.
	Children's dental check-up	No charge for scheduled cost of benefits, to yearly maximum.		$4,000 per person yearly. Predetermination required for services exceeding $500, or 10% penalty.

[* For more information about limitations and exceptions, see the plan or policy document at www.nwoadm.com or call 800-423-2924.]

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
- Cosmetic Surgery
- Habilitation Services
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Routine Foot Care
- Weight Loss Programs

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

- Bariatric Surgery
- Chiropractic Care (Spinal Subluxation)
- Dental Care
- Non-Emergency Care When Traveling Outside The U.S. (Subject To Precertification)
- Private-Duty Nursing
- Routine Eye 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the plan at 800-432-2924.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

[* For more information about limitations and exceptions, see the plan or policy document at www.nwoadm.com or call 800-423-2924.]

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	$400
Specialist copayment	$15
Hospital (facility) coinsurance	15%
Other coinsurance	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)*

Total Example Cost	$12,731

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$93
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,043

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

The plan's overall deductible	$400
Specialist copayment	$15
Hospital (facility) coinsurance	15%
Other coinsurance	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)*

Total Example Cost	$7,389

In this example, Joe would pay:

Cost Sharing	
Deductibles	$20
Copayments	$767
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,783
The total Joe would pay is	$2,570

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

The plan's overall deductible	$400
Specialist copayment	$15
Hospital (facility) coinsurance	15%
Other coinsurance	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)*

Total Example Cost	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles	$245
Copayments	$45
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$290

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