



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](http://www.cciio.cms.gov) or call 800-432-2924 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<u>Network</u> : \$400 Individual/\$800 Family; <u>Non-Network</u> : \$800 Individual/\$1600 Family.	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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes, network office and telemedicine visits, inpatient room/board, pre-op tests for in- and outpatient hospitalization, and second surgical opinions; all testing for COVID-19/SARS-CoV-2, including visit costs and tests to rule out diagnoses.	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.
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<u>Network</u> : \$1,500 Individual/\$3,000 Family; <u>Non-Network</u> : \$3,000 Individual/\$6,000 Family.	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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Copayments</u> , <u>premiums</u> , <u>deductibles</u> , <u>balance-billed</u> charges, health care this <u>plan</u> 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 <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call 800-810-2583 for a list of <u>network</u> providers.	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 most if you use an <u>out-of-network provider</u> , and you might receive a bill from an <u>out-of-network provider</u> for the difference between the <u>provider's</u> charge and what your plan pays ( <u>balance billing</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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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 clinic	Primary care visit to treat an injury or illness	\$15 <u>copayment</u> ; <u>deductible</u> does not apply.	25% <u>coinsurance</u> plus <u>balance billing</u> .	<p>Surgery performed in a doctor's office is subject to <u>deductible</u> and then 15% <u>network</u> / 25% non-network <u>coinsurance</u>.</p> <p>Telemedicine visits through Anthem's Live Health Online (livehealthonline.com) are covered at no charge and are not subject to the deductible.</p> <p>10 visits per calendar year limit for spinal subluxation and related services.</p> <p>One per year limit for routine mammograms and PAP smears. <u>Copayment</u> waived for immunizations received without office visit charge.</p> <p>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.</p>
	<u>Specialist</u> visit	\$15 <u>copayment</u> ; <u>deductible</u> does not apply.	25% <u>coinsurance</u> plus <u>balance billing</u> .	
	<u>Preventive care/screening/immunization</u>	\$15 <u>copayment</u> ; <u>deductible</u> does not apply.	25% <u>coinsurance</u> plus <u>balance billing</u> .	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus <u>balance billing</u> .	<p>Pre-op testing performed on an out-patient basis is covered at no charge and is not subject to the <u>deductible</u>.</p> <p>Testing for COVID-19 disease and the underlying SARS-CoV-2 virus, as well as any associated visit cost or cost to rule out other diagnoses is covered at no charge and is not subject to the deductible, so long as there is an HHS-declared public health emergency.</p>
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus <u>balance billing</u> .	

[\* For more information about limitations and exceptions, see the plan or policy document at [www.nwoadm.com](http://www.nwoadm.com) or call 800-432-2924.]

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or 800-818-6602.	Generic drugs	<b>Retail</b> \$10 <u>copayment</u> .	<b>Mail Order</b> \$20 <u>copayment</u> .	Participants are required to pay for prescriptions at non-participating pharmacies and submit their receipts for reimbursement, less the <u>copayment</u> and 25% <u>coinsurance</u> .  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. FDA-defined gene therapy drugs are excluded; such exclusion is subject to appeal rights.
	Brand drugs	\$20 <u>copayment</u> formulary; \$30 <u>copayment</u> non-formulary.	\$40 <u>copayment</u> formulary; \$60 <u>copayment</u> non-formulary.	
	<u>Specialty drugs</u>	Available through Accredo Specialty Pharmacy and under the terms of Accredo's pharmacy management program.		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus balance billing.	None.
	Physician/surgeon fees	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus balance billing.	None.
<b>If you need immediate medical attention</b>	Emergency room care	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus balance billing.	Participant responsible for 50% <u>coinsurance</u> for non-emergency care administered in an ER.
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus balance billing.	Air ambulance only covered if attending physician certifies that ground transport would have been inappropriate.
	<u>Urgent care</u>	\$15 <u>copayment</u> .	25% <u>coinsurance</u> plus <u>balance billing</u> .	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus <u>balance billing</u> .	Precertification required, or subject to penalty of 10%, up to \$500.
	Physician/surgeon fees	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus <u>balance billing</u> .	

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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 need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$15 <u>copayment</u> ; <u>deductible</u> does not apply.	25% <u>coinsurance</u> plus <u>balance billing</u> .	EAP assessment will give access to three free visits. Telemedicine visits through Anthem's Live Health Online (livehealthonline.com) are covered at no charge and are not subject to the deductible.
	Inpatient services	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus <u>balance billing</u> .	Precertification required, or subject to penalty of 10%, up to \$500.
<b>If you are pregnant</b>	Office visits	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus <u>balance billing</u> .	None.
	Childbirth/delivery professional services	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus <u>balance billing</u> .	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% <u>coinsurance</u> .	25% <u>coinsurance</u> plus <u>balance billing</u> .	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus <u>balance billing</u> .	Limited to 120 visits/4 hours per visit, per calendar year. Precertification required.
	<u>Rehabilitation services</u>	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus <u>balance billing</u> .	For inpatient convalescence, must be admitted within 14 days of hospital inpatient stay. Precertification required.  Limited to 20 physical therapy visits per condition.
	<u>Habilitation services</u>	Not covered.	Not covered.	N/A
	<u>Skilled nursing care</u>	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus <u>balance billing</u> .	Must be admitted within 14 days of hospital inpatient stay. Precertification required.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus <u>balance billing</u> .	None.
	<u>Hospice services</u>	15% <u>coinsurance</u> .	25% <u>coinsurance</u> plus <u>balance billing</u> .	Precertification required. Benefits limited to maximum Medicare reimbursement for geographic area. Requires election in lieu of other plan benefits.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$15 <u>copayment</u> .	Maximum benefit of \$35.	One exam per person, per year.
	Children's glasses	\$25 <u>copayment</u> 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 preventive services.		\$4,000 per person yearly maximum; orthodontia subject to \$2,000 per person lifetime maximum.

[\* For more information about limitations and exceptions, see the plan or policy document at [www.nwoadm.com](http://www.nwoadm.com) or call 800-432-2924.]

## 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 <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic Surgery</li><li>• Gene Therapy Drugs (FDA-defined)</li></ul>	<ul style="list-style-type: none"><li>• Habilitation Services</li><li>• Hearing Aids</li><li>• Infertility Treatment</li></ul>	<ul style="list-style-type: none"><li>• Long-Term Care</li><li>• Routine Foot Care</li><li>• Weight Loss Programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"><li>• Bariatric Surgery</li><li>• Chiropractic Care (Spinal Subluxation)</li></ul>	<ul style="list-style-type: none"><li>• Dental Care</li><li>• Non-Emergency Care When Traveling Outside The U.S. (Subject To Precertification)</li></ul>	<ul style="list-style-type: none"><li>• Private-Duty Nursing</li><li>• Routine Eye Care</li></ul>

**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](http://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](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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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.*—————

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:**

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

**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:**

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

**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:**

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