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, https://eoc.anthem.com/eocdps/aso. 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 1-877-512-7875 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000**/individual or **$2,000**/family. All Providers. Combined in-network and out-of-network.	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. Preventive care for In-Network Providers or covered prescription drugs.	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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$3,000**/individual or **$6,000**/family. All Providers. Combined in-network and out-of-network. This plan has a separate out-of-pocket maximum of **$1,000** individual and **$2,000** family for in-network and out-of-network prescription drugs.	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?	Services deemed not medically necessary by Anthem, premiums, balance-billing charges, 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 1-877-512-7875 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 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 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
		In-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% coinsurance	30% coinsurance	--------none--------
	Specialist visit	15% coinsurance	30% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	30% coinsurance	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	30% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30% coinsurance	Precertification is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	Retail: $10 co-pay / prescription Mail Order: $25 co-pay / prescription	Retail: $10 co-pay / prescription	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred brand drugs	Retail: $30 co-pay / prescription Mail Order: $75 co-pay / prescription	Retail: $30 co-pay / prescription	
	Non-preferred brand drugs	Retail: $60 co-pay / prescription Mail Order: $150 co-pay / prescription	Retail: $60 co-pay / prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	Precertification may be required.
If you need immediate medical attention	Emergency room care	15% coinsurance	Covered as In-Network	--------none--------
	Emergency medical transportation	No charge	No charge up to allowed amount	See contract of coverage for details.
	Urgent care	15% coinsurance	30% coinsurance	--------none--------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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)	15% coinsurance	30% coinsurance	Precertification is required.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	Precertification is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	30% coinsurance	Precertification may be required.
	Inpatient services	15% coinsurance	30% coinsurance	Precertification is required.
If you are pregnant	Office visits	15% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Benefit includes three ultrasounds per pregnancy. See contract of coverage for details. Precertification may be required.
	Childbirth/delivery professional services	15% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	15% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	No charge up to allowed amount	Limited to 50 visits/benefit period including private duty nursing. See contract of coverage for details.
	Rehabilitation services	15% coinsurance	30% coinsurance	Limits per benefit period: • Physical therapy: 40 visits. • Occupational therapy: 40 visits. • Speech therapy: 20 visits. See contract of coverage for details. Visit limits do not apply to Mental Health/Substance Abuse conditions.
	Habilitation services	15% coinsurance	30% coinsurance	
	Skilled nursing care	No charge	No charge up to allowed amount	Precertification is required. Limit of 60 days/benefit period. See contract of coverage for details.
	Durable medical equipment	15% coinsurance	30% coinsurance	Precertification may be required. See contract of coverage for details.
	Hospice services	15% coinsurance	30% coinsurance	See contract of coverage for details.
If your child needs dental or eye care	Children's eye exam	No Charge	30% coinsurance	Limited to routine vision screenings. Medical vision services are subject to office visit benefits.
	Children's glasses	Not covered	Not covered	--------none--------
	Children's dental check-up	Not covered	Not covered	--------none--------

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
- Dental care (Adult and Child)
- Hearing aids
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes
- Routine eye care (Adult)
- 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 24 manipulative visits/benefit period
- Coverage provided outside the United States. See www.bcbsglobalcore.com.
- Infertility treatment (limited to $5,000 per lifetime per family)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing only covered in the home. 50 visits/benefit period including home health 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: Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568
Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform
WELS VEBA Commission, c/o WELS Benefit Plans Office, N16W23377 Stone Ridge Dr., Waukesha, WI 53188, (414) 256-3299

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 1-877-512-7875.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-512-7875.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-512-7875.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-512-7875.

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	$1,000
Specialist *coinsurance*	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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,770**

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

The plan's overall deductible	$1,000
Specialist *coinsurance*	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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$900
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

The plan's overall deductible	$1,000
Specialist *coinsurance*	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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$10
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,110**

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