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, call1-888-421-2199 or visit www.myMPCbenefits.com. 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 https://www.healthcare.gov/sbc-glossary or call 1-888-421-2199 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network $600 person / $1,200 family. Out-of-network $1,200 person / $2,400 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. In-network preventive care, Primary Care visit and Specialist visit is covered before you meet your deductible.	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?	Yes. $100 person/$200 family for prescription drug coverage (combined retail and mail order); does not count toward overall deductible.	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?	For network providers $3,500 individual / $7,000 family; for out-of-network providers $7,000 individual / $14,000 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?	Premiums, balance-billing charges, penalties for failure to obtain pre-authorization or for non-compliance, services deemed not medically necessary by Medical Management and/or Anthem, and health care this plan doesn't cover. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

	cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.	
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 1-855-698-5676 for a list of in-network providers, or see www.express-scripts.com or call 1-877-207-1357 for participating pharmacies.	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
		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	$20 copay/office visit; deductible does not apply	40% coinsurance	
	Specialist visit	$50 copay/office visit; deductible does not apply	40% coinsurance	20 visit limit on manipulations, network and out-of-network combined.
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Preauthorization is required for imaging. If you don't get preauthorization for imaging (CT/PET scans, MRIs), benefits could be reduced or services not covered.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

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.myMPCbenefits.com	Generic drugs	$10 copay/prescription at retail; $25 copay/ prescription at mail order	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). You will pay 100% of the cost of a maintenance drug upon 3rd fill at pharmacy. Mail order or Smart90 Walgreens programs should be used. Does not apply to maintenance drugs where only 30-day fill is permitted. When formulary brand is purchased and generic is available, you will pay cost difference between generic and brand. Certain drug exclusions may apply. For drugs covered under medical (Anthem), coinsurance is 20% in-network and 40% out-of-network. **Please see "Important Questions" / "What is not included in the out-of-pocket limit?" above regarding certain specialty drugs that are considered non-essential health benefits.
	Formulary brand drugs	$30 copay/prescription at retail; $75 copay/ prescription at mail order	Not covered	
	Non-formulary brand drugs	$60 copay/prescription at retail; $150 copay/ prescription at mail order	Not covered	
	Specialty drugs**	Subject to brand copays listed above.**	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization required; otherwise benefits could be reduced or services not covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$200 copay/visit and 20% coinsurance	$200 copay/visit and 20% coinsurance	Copay applies first, then deductible and coinsurance. Copay waived if admitted. You will pay $200 copay /visit and 40% coinsurance for non-emergency use of network and out-of-network ER use.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$50 copay/visit, deductible does not apply	40% coinsurance	Copay for physician services only.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required; otherwise benefits could be reduced or services not covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	

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	$20 copay/office visit, deductible does not apply; Other outpatient 20% coinsurance	40% coinsurance	Preauthorization required for partial hospitalization and intensive outpatient therapy; otherwise benefits could be reduced or services not covered.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required; otherwise benefits could be reduced or services not covered. Out-of-network inpatient facilities must be licensed and accredited.
If you are pregnant	Office visits	$20 copay/office visit then 0% coinsurance	40% coinsurance	One copay per pregnancy for office visits services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	0% coinsurance	
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization required for inpatient. Physical, Occupational and Speech Therapy: review required at 30th visit.
	Habilitation services	20% coinsurance	40% coinsurance	All rehabilitation/habilitation visits count toward rehabilitation limit.
	Skilled nursing care	0% coinsurance	40% coinsurance	Preauthorization required. Limited to 180 days per calendar year and 365 days lifetime maximum per member. Must have hospital stay of 3 days before SNF would be covered. If patient readmitted to a SNF within 72 hours, no new hospital stay required.
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization for medical necessity is required for some durable medical equipment/prosthetics.
	Hospice services	0% coinsurance	0% coinsurance	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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
- Dental care (Adult)
- Long-term care
- Routine eye care (adult)
- 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.)

- Acupuncture (limitations apply)
- Bariatric surgery (treatment at Plan-recognized Center of Excellence)
- Chiropractic care (manipulations, regardless of service provider type, limited to 20 visits per member per year)
- Hearing aids (limitations apply)
- Infertility treatment (network provider only - lifetime limit of one attempt or cycle IVF or AI; lifetime maximum prescription drug treatment coverage not to exceed $15,000)
- Most coverage provided outside the U.S. See www.bcbsglobal.core.com.
- Private-duty nursing (in-home)

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'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. For information on continuing coverage under this plan, contact the plan at 1-888-421-2199.

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: You can contact Anthem Member Services at 1-855-698-5676 for medical/surgical and Express Scripts Member Services at 1-877-207-1357 for prescription. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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 1-855-698-5676.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-698-5676.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-855-698-5676.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-698-5676.

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	$600
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician 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	$600
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	$600
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs *(via mail order)*
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$700
Copayments	$500
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,280**

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

The plan's overall deductible	$600
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$600
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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