
 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, 1-877-324-3024. 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.myjoannbenefits.com or call 1-877-324-3024 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall <u>deductible</u> ?		Network	Non-Network	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 policy, the overall family <u>deductible</u> must be met by one or any combination of the family members before the <u>plan</u> begins to pay.
	Per participant:	\$2,000	\$4,500	
	Per family:	\$4,000	\$13,500	
Are there services covered before you meet your <u>deductible</u> ?	Yes. Preventive care benefits when performed by a <u>network provider</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 <u>deductibles</u> for specific services?	No.			You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?		Network	Non-Network	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.
	Per participant:	\$6,450	Unlimited	
	Per family:	\$12,900	Unlimited	
What is not included in the <u>out-of-pocket limit</u> ?	Non-covered services, services deemed not medically necessary by Medical Management, penalties for non-compliance, charges over the allowed amount.			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 <u>network provider</u> ?	<p>Yes, for medical: Anthem. See www.MyJOANNBenefits.com or call Quantum at 1-877-324-3024 for a list of <u>network providers</u>.</p> <p>Yes, for prescription drugs: CVS. For a list of retail and mail pharmacies, contact Quantum at www.MyJOANNBenefits.com or call 1-877-324-3024.</p>			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 a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> 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.

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> .
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 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)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
	<u>Specialist</u> visit	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need 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)	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible	Includes computed tomographic (CT) studies, coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, SPECT scans, and PET scans (excluding services rendered in an emergency room setting). Pre-certification is required for MRI/MRA and PET scans. Failure to obtain pre-certification may reduce benefits by \$300 per occurrence.

* For more information about limitations and exceptions, see the plan or policy document at www.MyJOANNBenefits.com

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at 1-800-776-1355.</p>	Generic drugs	<p>Retail: 15% co-insurance after deductible with a \$5 minimum and \$30 maximum</p> <p>Mail Order: 15% co-insurance after deductible with a \$10 minimum and \$60 maximum</p>	Not covered	<p>Retail and Specialty Prescriptions: Up to thirty (30) day supply</p> <p>CVS Retail and Mail Order Prescriptions: Up to ninety (90) day supply</p> <p>Step therapy requires preferred brands before a non-preferred brand.</p> <p>Not all <u>prescription drugs</u> are covered. To determine if a specific drug is covered under your <u>plan</u>, <u>contact Quantum at 1-877-324-3024.</u></p>
	Preferred brand drugs	<p>Retail: 25% co-insurance after deductible with a \$15 minimum and \$70 maximum</p> <p>Mail Order: 25% co-insurance after deductible with a \$30 minimum and \$140 maximum</p>	Not covered	
	Non-preferred brand drugs	<p>Retail: 45% co-insurance after deductible with a \$35 minimum and no maximum</p> <p>Mail Order: 45% co-insurance after deductible with a \$70 minimum and no maximum</p>	Not covered	
	<u>Specialty drugs</u>	30% co-insurance after deductible if you are not enrolled in the PrudentRx program	Not covered	

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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)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	40% co-insurance after deductible	Pre-certification is required. Failure to obtain pre-certification may reduce benefits by \$300 per occurrence.
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	
If you need immediate medical attention	<u>Emergency room care</u>	20% co-insurance after network deductible		If the visit to an emergency room is not deemed a true emergency, services will not be covered.
	<u>Emergency medical transportation</u>	20% co-insurance after network deductible		_____none_____
	<u>Urgent care</u>	20% co-insurance after deductible	40% co-insurance after deductible	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	Inpatient Rehabilitation Plan Year Maximum: One hundred twenty (120) days. Pre-certification is required. Failure to obtain pre-certification may reduce benefits by \$300 per occurrence.
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	This includes intensive psychiatric day treatment and partial hospitalization. Pre-certification is required for partial hospitalization and intensive outpatient services. Failure to obtain pre-certification may reduce benefits by \$300 per occurrence.
	Inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	This includes residential treatment. Pre-certification is required. Failure to obtain pre-certification may reduce benefits by \$300 per occurrence.
If you are pregnant	Office visits	20% co-insurance after deductible	40% co-insurance after deductible	Cost-sharing does not apply for <u>preventive services</u> . Depending on the type of services, <u>co-insurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% co-insurance after deductible	40% co-insurance after deductible	
	Childbirth/delivery facility services	20% co-insurance after deductible	40% co-insurance after deductible	
If you need help recovering or have	<u>Home health care</u>	20% co-insurance after deductible	40% co-insurance after deductible	Plan Year Maximum: Sixty (60) visits,

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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)	Non-Network Provider (You will pay the most)	
other special needs				combined with private duty nursing. Pre-certification is required. Failure to obtain pre-certification may reduce benefits by \$300 per occurrence.
	<u>Rehabilitation services</u>	20% co-insurance after deductible	40% co-insurance after deductible	Pre-certification is required in excess of forty (40) visits each for physical therapy, occupation therapy, and speech therapy. Failure to obtain pre-certification may reduce benefits by \$300 per occurrence.
	<u>Habilitation services</u>	20% co-insurance after deductible	40% co-insurance after deductible	Pre-certification is required. Failure to obtain pre-certification may reduce benefits by \$300 per occurrence.
	<u>Skilled nursing care</u>	20% co-insurance after deductible	40% co-insurance after deductible	Plan Year Maximum: One hundred twenty (120) days. Pre-certification is required. Failure to obtain pre-certification may reduce benefits by \$300 per occurrence.
	<u>Durable medical equipment</u>	20% co-insurance after deductible	40% co-insurance after deductible	Pre-certification is required for all rentals and any purchases over \$500. Failure to obtain pre-certification may reduce benefits by \$300 per occurrence.
	<u>Hospice services</u>	20% co-insurance after deductible	40% co-insurance after deductible	Benefit applies for plan participants who are terminally ill and life expectancy is less than twelve (12) months. Pre-certification is required. Failure to obtain pre-certification may reduce benefits by \$300 per occurrence.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	_____none_____
	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.)

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|-----------------------|----------------------------|------------------------|
| • Cosmetic Surgery | • Long-Term Care | • Routine Foot Care |
| • Dental Care (Adult) | • Routine Eye Care (Adult) | • Weight Loss Programs |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.MyJOANNBenefits.com

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

- Acupuncture – Limited to forty (40) visits per plan year.
- Bariatric Surgery – Limited to a lifetime maximum of one (1) surgery.
- Chiropractic Care – Limited to forty (40) visits per plan year.
- Hearing Aids – Limited to \$3,000 per ear every three (3) years.
- Infertility – Limited to a lifetime maximum of \$25,000 for all infertility treatment services.
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing – Limited to sixty (60) visits per plan year, combined with 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's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Plan Administrator at 1-866-451-3399. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Care Coordinators to assist the plan administrator with claims adjudication. The Care Coordinators name, address, and telephone number are:

MyQHealth Care Coordinators
5240 Blazer Way
Dublin, OH 43017
1-877-324-3024

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 1-877-324-3024.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-324-3024.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-324-3024.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-324-3024.

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To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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 \$2,000
- Specialist cost sharing 20%
- Hospital (facility) cost sharing 20%
- Other cost sharing 20%

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>	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$4,100

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

- The plan's overall deductible \$2,000
- Specialist cost sharing 20%
- Hospital (facility) cost sharing 20%
- Other cost sharing 20%

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>	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,080

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

- The plan's overall deductible \$2,000
- Specialist cost sharing 20%
- Hospital (facility) cost sharing 20%
- Other cost sharing 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,200

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