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 deductible?		**Network**	**Non-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.
	Per participant:	$1,500	$3,500	
	Per family:	$3,000	$10,500	
Are there services covered before you meet your deductible?	**Yes.** Preventive care when performed by a network provider and benefits where a co-payment applies.			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.** Prescription drugs for preferred and non-preferred prescriptions.			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.
		Network	**Non-Network**	
	Per participant:	$50	N/A	
	Per family:	$150	N/A	
What is the out-of-pocket limit for this plan?		**Network**	**Non-Network**	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.
	Per participant:	$6,350	Unlimited	
	Per family:	$12,700	Unlimited	
What is not included in the out-of-pocket limit?	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 out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes, for medical:** Anthem. See www.MyJOANNBenefits.com or call Quantum at			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

	1-877-324-3024 for a list of network providers. **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.	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)	Non-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% co-insurance after deductible	40% co-insurance after deductible	——————none——————
	Specialist visit	20% co-insurance after deductible	40% co-insurance after deductible	——————none——————
	Preventive care/screening/ immunization	No charge	Not covered	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% 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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-800-776-1355.	Generic drugs	**Retail:** 20% co-insurance after deductible with a $10 minimum and $25 maximum **Mail Order:** 20% co-insurance after deductible with a $20 minimum and $70 maximum	Not covered	**Retail and Specialty Prescriptions:** Up to thirty (30) day supply **CVS Retail and Mail Order Prescriptions:** Up to ninety (90) day supply Step therapy requires preferred brands before a non-preferred brand. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, contact Quantum at 1-877-324-3024,
	Preferred brand drugs	**Retail:** 20% co-insurance after deductible with a $20 minimum and $65 maximum **Mail Order:** 20% co-insurance after deductible with a $40 minimum and $130	Not covered	
	Non-preferred brand drugs	**Retail:** 35% co-insurance after deductible with a $40 minimum and no maximum **Mail Order:** 35% co-insurance after deductible with a $80 minimum and no maximum	Not covered	
	Specialty drugs	30% co-insurance after deductible if you are not enrolled in the PrudentRx program	Not covered	Contact PrudentRx at 1-800-578-4403 for specialty drug information.
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

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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)	
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	per occurrence.
If you need immediate medical attention	Emergency room care	**Emergency Room:** $250 co-payment plus 20% co-insurance after network deductible **Physician Charges:** 20% co-insurance after network deductible		If the visit to an emergency room is not deemed a true emergency, services will not be covered. The emergency room co-payment is waived if admitted.
	Emergency medical transportation	20% co-insurance after network deductible		——————————none——————————
	Urgent care	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 preventive services. Depending on the type of services, co-insurance or deductible 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	Home health care	20% co-insurance after deductible	40% co-insurance after deductible	**Plan Year Maximum:** Sixty (60) visits,

* 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)	
other special needs				combined with private duty nursing. **Pre-certification is required.** Failure to obtain pre-certification may reduce benefits by $300 per occurrence.
	Rehabilitation services	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.
	Habilitation services	20% co-insurance after deductible	40% co-insurance after deductible	
	Skilled nursing care	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.
	Durable medical equipment	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.
	Hospice services	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.)

- Cosmetic Surgery
- Dental Care (Adult)
- Long-Term Care
- Routine Eye Care (Adult)
- Routine Foot Care
- 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 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, kwiijigo holne' 1-877-324-3024.

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

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

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

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	$1,500
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,700**

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

The plan's overall deductible	$1,500
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,800**

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

The plan's overall deductible	$1,500
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

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