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, see **plan** or Benefits Booklet document at go/benefitdocuments. 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 (855) 431-5540 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,700**/individual or **$3,400**/family for In-Network Providers. **$3,400**/ individual or **$6,800**/family for Out-of-Network Providers.	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care for In-Network and Out-of-Network Providers.	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?	**$2,600**/ individual or **$5,200**/family for In-Network Providers. **$5,200**/ individual or **$10,400**/family for Out-of-Network Providers.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Services deemed not medically necessary by Medical Management and/or Anthem, Provider charges in excess of the maximum reimbursable charge 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. **NY Blue Access PPO** network if you reside in NY (excluding Suffolk County), **GA Blue Open Access POS** network if you reside in GA, **Blue Card PPO** network for all other areas. See includedhealth.com/google or call (855) 431-5540 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	10% coinsurance	30% coinsurance	--------none--------
	Specialist visit	10% coinsurance	30% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	No charge	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)	10% coinsurance	30% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	--------none--------

* For more information about limitations and exceptions, see **plan** or Benefits Booklet document at go/benefitdocuments.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Tier 1 - Typically Generic	Up to 30 days' supply 10% coinsurance after deductible is met Up to 90 days' supply 10% coinsurance after deductible is met	Up to 30 days' supply 50% coinsurance after deductible is met	**Carved out to CVS Caremark:** **Preferred Brands** - Brand-name drug without a generic equivalent. **Non-Preferred Brands** - Brand-name drug with a generic equivalent. **Generic Drug Substitution Edit**: If your doctor doesn't specify Dispense as Written (DAW) on a Non-Preferred Brand prescription and gives you the choice to substitute for a generic equivalent, you may pay the applicable Non-Preferred Brand copay plus the cost difference between the brand-name drug and the generic equivalent if you request the Non-Preferred Brand. **90 Days' Supply** - Allowed at CVS Caremark Mail Service Pharmacy or CVS Pharmacy only. **Specialty** - Hepatitis B, HIV/AIDS and Transplant drugs may be filled at any participating retail pharmacy, which include non-CVS retail pharmacies, or CVS Specialty Pharmacy. Note: **Fertility drugs** can only be filled through Progyny Rx. Call (888) 461-4997 or visit go/fertility for details. **Advanced Control Specialty Formulary** – List of specialty medications covered with an increased
	Tier 2 - Typically Preferred Brand / Non-Preferred Generic	Up to 30 days' supply 20% coinsurance after deductible is met Up to 90 days' supply 20% coinsurance after deductible is met	Up to 30 days' supply 50% coinsurance after deductible is met	
	Tier 3 - Typically Non-Preferred Brand	Up to 30 days' supply 30% coinsurance after deductible is met Up to 90 days' supply 30% coinsurance after deductible is met	Up to 30 days' supply 50% coinsurance after deductible is met	
	Tier 4 - Typically Specialty (brand and generic)	Up to 30 days' supply 30% coinsurance ($180 max) after deductible is met	Not covered	

* For more information about limitations and exceptions, see **plan** or Benefits Booklet document at go/benefitdocuments.

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)	
				focus on clinically effective specialty medications. Drugs not covered on the specialty formulary will require a medical necessity exception. **Utilization Management**: Certain specialty and non-specialty drugs may require a coverage review or prior authorization, which uses evidence-based criteria to evaluate whether your prescription therapy is medically safe and appropriate.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	10% coinsurance	30% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	10% coinsurance	Covered as In-Network	10% coinsurance for Emergency Room Physician Fee.
	Emergency medical transportation	10% coinsurance	Covered as In-Network	--------none--------
	Urgent care	10% coinsurance	10% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	10% coinsurance	30% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 10% coinsurance Other Outpatient 10% coinsurance	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	10% coinsurance	30% coinsurance	10% coinsurance for Inpatient Physician Fee In-Network Providers. 30% coinsurance for Inpatient Physician Fee Out-of-Network Providers.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	

* For more information about limitations and exceptions, see **plan** or Benefits Booklet document at go/benefitdocuments.

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)	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	--------none--------
	Rehabilitation services	10% coinsurance	30% coinsurance	*See Therapy Services section
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	100 days limit/benefit period.
	Durable medical equipment	10% coinsurance	30% coinsurance	--------none--------
	Hospice services	10% coinsurance	10% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

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
- Long-term care
- Routine eye care
- Routine foot care unless you have been diagnosed with diabetes
- Weight loss program

* For more information about limitations and exceptions, see **plan** or Benefits Booklet document at go/benefitdocuments.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Infertility treatment - Eligible for Progyny 4 Smart Cycles with 10% coinsurance after deductible. Pre-authorized fertility medications for up to 30 days' supply at a time are included via Progyny Rx at 30% coinsurance ($180 max) after the deductible is met applied to only the initial fill of each medication for each treatment. Call (888) 461-4997 or visit go/fertility for details.
• Bariatric surgery	• Hearing aids	• Non-emergency care when traveling outside the U.S. (Work- travel (short-term assignment, <6 month) or related to a student studying abroad, routine/wellness/sick visits allowed at out-of- network benefits covered at the maximum allowed for student or Googler/family members traveling with them). See www.bcbsglobalcore.com • Private-duty nursing

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, PO Box 54159, Los Angeles, CA 90054-0159

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

* For more information about limitations and exceptions, see **plan** or Benefits Booklet document at go/benefitdocuments.

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.

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

* For more information about limitations and exceptions, see **plan** or Benefits Booklet document at go/benefitdocuments.

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	$1,700
■ Specialist *coinsurance*	10%
■ Hospital (facility) *coinsurance*	10%
■ Other *coinsurance*	10%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$2,900**

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

■ The plan's overall deductible	$1,700
■ Specialist *coinsurance*	10%
■ Hospital (facility) *coinsurance*	10%
■ Other *coinsurance*	10%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$545
What isn't covered	
Limits or exclusions	$250
The total Joe would pay is	**$2,495**

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

■ The plan's overall deductible	$1,700
■ Specialist *coinsurance*	10%
■ Hospital (facility) *coinsurance*	10%
■ Other *coinsurance*	10%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,720**

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