




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, contact the Plan Sponsor at (859) 858-3511 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 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$300</b> /individual or <b>\$600</b> /family for Network Providers. <b>\$600</b> /individual or <b>\$1,200</b> /family for Out-of-Network Providers.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. In-network <a href="#">preventive care</a> is covered before you meet your deductible.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>\$2,500</b> /individual or <b>\$5,000</b> /family for Network Providers. <b>\$5,000</b> /individual or <b>\$10,000</b> /family for Out-of-Network Providers.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Copayments, penalties, pharmacy charges, Out-of-Network transplant charges, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.anthem.com">www.anthem.com</a> or call Aspirant at 1-855-982-2583 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /office visit (deductible does not apply)	40% <a href="#">coinsurance</a>	Additional costs may apply based on services provided.
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a> /office visit (deductible does not apply)	40% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	\$30 <a href="#">copay</a> /office visit (deductible does not apply)	40% <a href="#">coinsurance</a>	Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Cost Share in office setting (deductible does not apply) or 20% <a href="#">coinsurance</a> (based on place of service)	40% <a href="#">coinsurance</a>	-----None-----
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Precertification is required.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs (Tier 1)	\$10 <a href="#">copay</a> /prescription (retail) and \$20 <a href="#">copay</a> /prescription (mail order)	50% <a href="#">coinsurance</a> , minimum \$60 copayment (retail only)	Covers up to a 30-day supply at retail pharmacy, up to a 90-day supply through mail order pharmacy, and up to a 30-day supply for Specialty drugs. Your plan uses a preferred drug list which identifies the status of covered drugs. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs (Tier 2)	\$30 <a href="#">copay</a> /prescription (retail) and \$75 <a href="#">copay</a> /prescription (mail order)	50% <a href="#">coinsurance</a> , minimum \$60 copayment (retail only)	
	Non-preferred brand drugs (Tier 3)	\$60 <a href="#">copay</a> /prescription (retail) and \$150 <a href="#">copay</a> /prescription (mail order)	50% <a href="#">coinsurance</a> , minimum \$60 copayment (retail only)	
	<a href="#">Specialty drugs</a> (Tier 4)	Same cost as Generic/Preferred/Non-Preferred Drugs	50% <a href="#">coinsurance</a> , minimum \$60 copayment (retail only)	Out-of-Network mail order is not covered.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Precertification is required.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----None-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$75 <a href="#">copay</a> /visit (deductible does not apply)	Covered as In-Network	Copay waived if admitted. Non-emergency care is not covered.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	Covered as In-Network	-----None-----
	<a href="#">Urgent care</a>	\$35 <a href="#">copay</a> /visit (deductible does not apply)	\$35 <a href="#">copay</a> /visit (deductible does not apply)	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Precertification is required. Physical Medicine & Rehabilitation is limited to 60 days/year combined Network and Out-of-Network (limit includes Day Rehabilitation Therapy Services on an outpatient basis).
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <a href="#">copay</a> /office visit (deductible does not apply) or 20% <a href="#">coinsurance</a> (based on place of service)	40% <a href="#">coinsurance</a>	-----None-----
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Precertification is required.
If you are pregnant	Office visits	\$30 <a href="#">copay</a> /office visit (deductible does not apply) or 20% <a href="#">coinsurance</a> (based on place of service)	40% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	

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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Precertification is required. Limited to 90 days/calendar year combined Network and Out-of-Network.
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copay</a> /office visit (deductible does not apply) or 20% <a href="#">coinsurance</a> (based on place of service)	40% <a href="#">coinsurance</a>	Precertification is required for cardiac rehabilitation. Therapy limits are combined Network & Out-of-Network: Physical Therapy: 20 visits/calendar year Occupational Therapy: 20 visits/calendar year Speech Therapy: 20 visits/calendar year Manipulation Therapy: 12 visits/calendar year Cardiac Rehabilitation: 36 visits/calendar year Pulmonary Rehabilitation: 20 visits/calendar year
	<a href="#">Habilitation services</a>	\$30 <a href="#">copay</a> /office visit (deductible does not apply) or 20% <a href="#">coinsurance</a> (based on place of service)	40% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Precertification is required. Limited to 90 days/calendar year combined Network and Out-of-Network.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Precertification is required. Hearing Aids are limited to 1 per hearing impaired ear every 36 months for members under the age of 18.
	<a href="#">Hospice services</a>	No charge	No charge	-----None-----
<b>If your child needs dental or eye care</b>	Children's eye exam	\$30 <a href="#">copay</a> /office visit (deductible does not apply)	40% <a href="#">coinsurance</a>	Coverage limited to one exam/calendar year.
	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       | • Dental Care           | • Routine Foot Care    |
| • Bariatric Surgery | • Infertility Treatment | • Weight Loss Programs |
| • Cosmetic Surgery  | • Long-Term Care        |                        |

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

- Chiropractic Care
- Routine Eye Care
- Hearing Aids
- Non-emergency care when traveling outside the U.S.
- 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: Aspirant at 1-877-309-2955, the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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: Aspirant at 1-877-309-2955 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact Kentucky Department of Insurance, Consumer Protection Division at 1-800-595-6053 or <http://healthinsurancehelp.ky.gov>.

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 1-877-309-2955.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-309-2955.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-309-2955.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-309-2955.

—————*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$120
Coinsurance	\$2,200
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,620</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$210
Coinsurance	\$1,420
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,930</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$300
■ <a href="#">Specialist copayment</a>	\$30
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$75
Coinsurance	\$320
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$695</b>