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 deductible?	**$1,000**/individual or **$2,000**/family for Network Providers. **$2,000**/individual or **$4,000**/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 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 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.
Are there other deductibles for specific services?	Yes. **$200** Pharmacy Deductible applies to Tiers II and III for Network and Out-of-Network.	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?	**$4,000**/individual or **$8,000**/family for Network Providers. **$8,000**/individual or **$16,000**/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, 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?	Copayments, penalties, pharmacy charges, Out-of-Network transplant charges, 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. See www.anthem.com or call Aspirant at 1-855-982-2583 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
		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	$30 copay/office visit (deductible does not apply)	40% coinsurance	Additional costs may apply based on services provided.
	Specialist visit	$30 copay/office visit (deductible does not apply)	40% coinsurance	
	Preventive care/screening/ immunization	$30 copay/office visit (deductible does not apply)	40% coinsurance	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)	No Cost Share in office setting (deductible does not apply) or 20% coinsurance (based on place of service)	40% coinsurance	----------None----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Precertification is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs (Tier 1)	$10 copay/prescription (retail) and $20 copay/ prescription (mail order)	50% coinsurance, minimum $60 copayment (retail only)	$200 pharmacy deductible applies for Tiers II and III, Network and Out-of-Network. 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. Out-of-Network mail order is not covered.
	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail) and $75 copay/ prescription (mail order)	50% coinsurance, minimum $60 copayment (retail only)	
	Non-preferred brand drugs (Tier 3)	$60 copay/prescription (retail) and $150 copay/ prescription (mail order)	50% coinsurance, minimum $60 copayment (retail only)	
	Specialty drugs (Tier 4)	Same cost as Generic/ Preferred/Non-Preferred Drugs	50% coinsurance, minimum $60 copayment (retail only)	

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

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% coinsurance	40% coinsurance	Precertification is required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	----------None----------
If you need immediate medical attention	Emergency room care	$75 copay/visit (deductible does not apply)	Covered as In-Network	Copay waived if admitted. Non-emergency care is not covered.
	Emergency medical transportation	20% coinsurance	Covered as In-Network	----------None----------
	Urgent care	$35 copay/visit (deductible does not apply)	$35 copay/visit (deductible does not apply)	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	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% coinsurance	40% coinsurance	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit (deductible does not apply) or 20% coinsurance (based on place of service)	40% coinsurance	----------None----------
	Inpatient services	20% coinsurance	40% coinsurance	Precertification is required.
If you are pregnant	Office visits	$30 copay/office visit (deductible does not apply) or 20% coinsurance (based on place of service)	40% coinsurance	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	

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

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 help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Precertification is required. Limited to 90 days/calendar year combined Network and Out-of-Network.
	Rehabilitation services	$30 copay/office visit (deductible does not apply) or 20% coinsurance (based on place of service)	40% coinsurance	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
	Habilitation services	$30 copay/office visit (deductible does not apply) or 20% coinsurance (based on place of service)	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification is required. Limited to 90 days/calendar year combined Network and Out-of-Network.
	Durable medical equipment	20% coinsurance	40% coinsurance	Precertification is required. Hearing Aids are limited to 1 per hearing impaired ear every 36 months for members under the age of 18.
	Hospice services	No charge	No charge	----------None----------
If your child needs dental or eye care	Children's eye exam	$30 copay/office visit (deductible does not apply)	40% coinsurance	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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long-Term Care
- Routine Foot Care
- Weight Loss Programs

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

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, or the Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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. 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, kwiijigo holne' 1-877-309-2955.

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 the plan or policy document.

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	$1000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$120
Coinsurance	$2,360
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,480**

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

The plan's overall deductible	$1000
Specialist copayment	$30
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
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$210
Coinsurance	$1,280
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,490**

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

The plan's overall deductible	$1000
Specialist copayment	$30
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$75
Coinsurance	$180
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,255**

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