



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 IIS Benefits at 1-877-257-3826. 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](http://www.healthcare.gov/sbc-glossary) or call 1-877-257-3826 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	<b>Network Providers: \$2,000 individual/\$4,000 family</b> <b>Out-of-Network Providers: \$20,000 individual/\$40,000 family</b> Per calendar year	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> (Embedded).
Are there services covered before you meet your <u>deductible</u> ?	<b>Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u></b>	The <u>plan</u> covers some items and services even if you haven't 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	<b>No.</b>	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> ?	For <u>network providers</u> <b>\$2,650 individual/\$5,300 family.</b> For <u>Out-of-network providers</u> Unlimited	The <u>out-of-pocket</u> limit 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 (Embedded).
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance billed</u> charges, penalties for failure to obtain <u>Preauthorization</u> for services and health care this <u>plan</u> doesn't cover.	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> ?	<b>Yes. HMO.</b> See <a href="http://www.anthem.com">www.anthem.com</a> or call 1-855-330-1218 for a list of <u>Network providers</u> .	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 charge</u> 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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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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)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 Copay per visit <a href="#">deductible</a> does not apply	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	None
	<a href="#">Specialist</a> visit	\$55 Copay per visit <a href="#">deductible</a> does not apply	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	You may have to pay for services that are not <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	None
	Imaging (CT/PET scans, MRIs)	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available by contacting EHIM Rx at 1-800-311-3446 or <a href="#">www.ehimrx.com</a>	Generic drugs	In Network deductible & 20% coinsurance	Not Covered	*See Prescription Drug Section
	Preferred brand drugs	In Network deductible & 20% coinsurance	Not Covered	
	Non-preferred brand drugs	In Network deductible & 20% coinsurance	Not Covered	
	<a href="#">Specialty drugs</a>	In Network deductible & 20% coinsurance	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)	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	<a href="#">Preauthorization</a> is required for certain services, for details call plan administrator. Contact 1-800-336-7767 for Preauthorization
	Physician/surgeon fees	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	In Network deductible & 20% coinsurance		All facilities are covered as in-network subject to meeting “emergency” criteria. <b>Ground Ambulance Only</b>
	<a href="#">Emergency medical transportation</a>	In Network deductible & 20% coinsurance		
	<a href="#">Urgent care</a>	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	<a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed. Contact 1-800-336-7767 for Preauthorization
	Physician/surgeon fees	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	None
	Inpatient services	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	<a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed. Contact 1-800-336-7767 for Preauthorization
If you are pregnant	Office visits	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">cost sharing</a> may apply. Maternity

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)	
			Medicare allowable.	care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <a href="#">Preauthorization</a> is required for inpatient stay over 48 hours for a vaginal delivery or 96 hours for a cesarean section.
	Childbirth/delivery professional services	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	
	Childbirth/delivery facility services	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	Limited to 20 visits per Calendar Year. <a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed. Contact 1-800-336-7767 for Preauthorization
	<a href="#">Rehabilitation services</a>	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	Limited to 20 visits (combined Physical, Occupational, and Speech Therapy) per Calendar year. <a href="#">Preauthorization</a> is required for Speech Therapy or benefit reduces to 50% of the allowed. Contact 1-800-336-7767 for Preauthorization
	<a href="#">Habilitation services</a>	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	Limited to 20 visits (combined Physical, Occupational, and Speech Therapy) per Calendar year. <a href="#">Preauthorization</a> is required for Speech Therapy or benefit reduces to 50% of the allowed. Contact 1-800-336-7767 for Preauthorization.
	<a href="#">Skilled nursing care</a>	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	Limited to 60 visits/Days per Calendar year. <a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed. Contact 1-800-336-7767 for Preauthorization.
	<a href="#">Durable medical equipment</a>	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	<a href="#">Preauthorization</a> is required for certain items or benefit reduces to 50% of the allowed, for details call plan administrator. Contact 1-800-336-7767 for Preauthorization.
	<a href="#">Hospice services</a>	In Network deductible & 20% coinsurance	10% coinsurance after deductible. Plan pays at 125% of	<a href="#">Preauthorization</a> is required or benefit reduces to 50% of the allowed. Contact 1-800-336-7767 for Preauthorization

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)	
			Medicare allowable.	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for children's eye exam
	Children's glasses	Not Covered	Not Covered	No coverage for children's glasses
	Children's dental check-up	Not Covered	Not Covered	No coverage for children's dental checkup

#### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Alternative Medicine/Homeopathy</li> <li>Applied Behavior Analysis(ABA Therapy)</li> <li>Bariatric Surgery</li> <li>Bereavement Counseling</li> <li>Biofeedback</li> <li>Cosmetic Surgery</li> <li>Dental Care (routine) Adult and Child except as required by ACA</li> </ul>	<ul style="list-style-type: none"> <li>Eye Care (routine) Adult and Child except as required by ACA</li> <li>Foot Care (routine)</li> <li>Half-way house</li> <li>Infertility Treatment/Services (Basic Testing is covered)</li> <li>Long Term Care</li> <li>Massage Therapy</li> <li>Methadone Clinics</li> </ul>	<ul style="list-style-type: none"> <li>Non-Emergency Care outside the U.S.</li> <li>Non-Emergency Care in the ER setting</li> <li>Oral Surgery</li> <li>Private Duty Nursing</li> <li>Respite Care</li> <li>Specialty Medications</li> <li>TMJ Treatment and Appliances</li> <li>Weight Loss Programs</li> </ul>	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)			
<ul style="list-style-type: none"> <li>Chiropractic Care – Limited to 20 visits per Calendar Year</li> </ul>			

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-877-257-3826. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. 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: 1-877-257-3826

**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 [2](#).

**Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al 1-877-257-3826

\_\_\_\_\_ *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>	\$2000
■ <a href="#">Specialist</a> Copayment	N/A
■ 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>\$12,731</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2000
Copayments	\$0
Coinsurance	\$1600
What isn't covered	
Limits or exclusions	\$573
<b>The total Peg would pay is</b>	<b>\$4,173</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>	\$2000
■ <a href="#">Specialist</a> Copayment	N/A
■ 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>\$7,389</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2000
Copayments	\$0
Coinsurance	\$1077
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$3,132</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>	\$2000
■ <a href="#">Specialist</a> Copayment	N/A
■ 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>\$1,925</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1925
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,925</b>