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 or call 1-877-257-3826 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Network Providers: No Deductible** **Out-of-Network Providers: $13,000 individual/$26,000 family** **Per calendar year**	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 (Embedded).
Are there services covered before you meet your deductible?	**Yes. Preventive care services are covered before you meet your deductible**	The plan covers some items and services even if you haven't 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?	For network providers **$650 individual/$1,300 family.** For Out-of-network providers Unlimited	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 (Embedded).
What is not included in the out-of-pocket limit?	Premiums, balance billed charges, penalties for failure to obtain Preauthorization for services 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. HMO.** See **www.anthem.com or call 1-855-330-1218** 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	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	**None**
	Specialist visit	$55 Copay	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	**None**
	Preventive care/screening/ immunization	No Charge	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	You may have to pay for services that are not 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)	$35 Copay X-Ray $35 Copay Lab	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	**None**
	Imaging (CT/PET scans, MRIs)	In Network deductible & 10% 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 **prescription drug coverage** is available by contacting EHIM Rx at 1-800-311-3446 or www.ehimrx.com	Generic drugs	$10 Copay	Not Covered	*See Prescription Drug Section
	Preferred brand drugs	$35 Copay	Not Covered	
	Non-preferred brand drugs	$75 Copay	Not Covered	
	Specialty drugs	In Network deductible & 10% 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 & 10% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	Preauthorization is required for certain services, for details call plan administrator. Contact 1-800-336-7767 for Preauthorization
	Physician/surgeon fees	In Network deductible & 10% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	None
If you need immediate medical attention	Emergency room care	In Network deductible & 10% coinsurance		All facilities are covered as in-network subject to meeting "emergency" criteria. **Ground Ambulance Only**
	Emergency medical transportation	In Network deductible & 10% coinsurance		
	Urgent care	$75 Copay	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 & 10% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	Preauthorization is required or benefit reduces to 50% of the allowed. Contact 1-800-336-7767 for Preauthorization
	Physician/surgeon fees	In Network deductible & 10% 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	$55 Copay	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	None
	Inpatient services	In Network deductible & 10% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	Preauthorization is required or benefit reduces to 50% of the allowed. Contact 1-800-336-7767 for Preauthorization
If you are pregnant	Office visits	$30 Copay	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	Cost sharing does not apply to certain preventive services. Depending on the type of services, cost sharing may apply. Maternity care may include tests and services described

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)	
	Childbirth/delivery professional services	In Network deductible & 10% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	elsewhere in the SBC (i.e. ultrasound). Preauthorization is required for inpatient stay over 48 hours for a vaginal delivery or 96 hours for a cesarean section.
	Childbirth/delivery facility services	In Network deductible & 10% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	
If you need help recovering or have other special health needs	Home health care	In Network deductible & 10% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	Limited to 20 visits per Calendar Year. Preauthorization is required or benefit reduces to 50% of the allowed. Contact 1-800-336-7767 for Preauthorization
	Rehabilitation services	In Network deductible & 10% 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. Preauthorization is required for Speech Therapy or benefit reduces to 50% of the allowed. Contact 1-800-336-7767 for Preauthorization
	Habilitation services	In Network deductible & 10% 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. Preauthorization is required for Speech Therapy or benefit reduces to 50% of the allowed. Contact 1-800-336-7767 for Preauthorization.
	Skilled nursing care	In Network deductible & 10% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	Limited to 60 visits/Days per Calendar year. Preauthorization is required or benefit reduces to 50% of the allowed. Contact 1-800-336-7767 for Preauthorization.
	Durable medical equipment	In Network deductible & 10% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	Preauthorization 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.
	Hospice services	In Network deductible & 10% coinsurance	10% coinsurance after deductible. Plan pays at 125% of Medicare allowable.	Preauthorization 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)	
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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Alternative Medicine/Homeopathy
- Applied Behavior Analysis(ABA Therapy)
- Bariatric Surgery
- Bereavement Counseling
- Biofeedback
- Cosmetic Surgery
- Dental Care (routine) Adult and Child except as required by ACA
- Eye Care (routine) Adult and Child except as required by ACA
- Foot Care (routine)
- Half-way house
- Infertility Treatment/Services (Basic Testing is covered)
- Long Term Care
- Massage Therapy
- Methadone Clinics
- Non-Emergency Care outside the U.S.
- Non-Emergency Care in the ER setting
- Oral Surgery
- Private Duty Nursing
- Respite Care
- Specialty Medications
- TMJ Treatment and Appliances
- Weight Loss Programs

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

- Chiropractic Care – Limited to 20 visits per Calendar Year

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, or the U.S. 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: 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 plan's overall deductible	N/A
Specialist *Copayment*	$55
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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$55
Coinsurance	$595
What isn't covered	
Limits or exclusions	$573
The total Peg would pay is	**$1,223**

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

The plan's overall deductible	N/A
Specialist *Copayment*	$55
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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$495
Coinsurance	$155
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$705**

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

The plan's overall deductible	N/A
Specialist *Copayment*	$55
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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$193
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$193**

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