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, 216-267-3344 or 888-424-7488. 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 216-267-3344 or 888-424-7488 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$150/Individual or $300/family	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. 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. 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 $1,050 individual / $5,000 family; for out-of-network providers Not Applicable	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. This plan does not have out-of-pocket limits on your expenses at out-of-network providers.
What is not included in the out-of-pocket limit?	Copayments for certain services, 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/health-insurance/provider-directory/searchcriteria or call 216-267-3344 or 888-424-7488 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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	$10 copay/office visit and 5% coinsurance for other outpatient services; deductible does not apply	15% coinsurance	$520 calendar year maximum for chiropractic services with no co-pay
	Specialist visit	$10 copay/visit and 5% coinsurance for other outpatient services	15% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service.
	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 you need are preventive. Then check what your plan will pay for. Visitation limits - 6 visits/year - under 1 year old; 2 visits/year - 1 to 2 years; 1 visit/year - 3 years to 25 years.
If you have a test	Diagnostic test (x-ray, blood work)	5% coinsurance	15% coinsurance	None
	Imaging (CT/PET scans, MRIs)	5% coinsurance	15% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.smw33benefits.org	Generic drugs (Tier 1)	15% coinsurance (retail & mail order)	15% coinsurance (retail & mail order)	Covers up to a 30-day supply or 100 unit dose (retail subscription); 31-90 day supply or 300 unit dose (mail order prescription). If you choose a brand name drug when a generic drug is available, you are also required to pay the difference in cost between the name brand and generic in addition to the coinsurance amount. This difference in cost is additional and not counted toward your overall out of pocket maximum.
	Brand drugs without available generic alternative (Tier 2)	15% coinsurance (retail & mail order)	15% coinsurance (retail & mail order)	
	Brand drugs with available generic alternative (Tier 3)	25% coinsurance (retail & mail order)	25% coinsurance (retail & mail order)	
	Specialty drugs (Tier 4)	25% coinsurance (retail & mail order)	25% coinsurance (retail & mail order)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance	15% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 100% of the total cost of the service.
	Physician/surgeon fees	5% coinsurance	15% coinsurance	None

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 immediate medical attention	Emergency room care	$50 copay/visit and 5% coinsurance	$50 copay/visit and 15% coinsurance plus the difference between (a) the providers' charges and (b) the amount collected from the Plan and co-pay	None
	Emergency medical transportation	5% coinsurance	15% coinsurance	
	Urgent care	$10 copay/visit and 5% coinsurance;	15% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	5% coinsurance	15% coinsurance	None
	Physician/surgeon fees	5% coinsurance	15% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	5% coinsurance	15% coinsurance	Must be treated by an MD and/or PHD; other licensed health practitioners must be under the direction of and must bill the Plan through these professionals
	Inpatient services	5% coinsurance	15% coinsurance	
If you are pregnant	Office visits	$10 copay/office visit and 5% coinsurance for other outpatient services	15% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	5% coinsurance	15% coinsurance	
	Childbirth/delivery facility services	5% coinsurance	15% coinsurance	
If you need help recovering or have other special health needs	Home health care	5% coinsurance	15% coinsurance	None
	Rehabilitation services	5% coinsurance	15% coinsurance	Only Physical/ Occupational/ Speech therapies are covered and only if provided by a licensed therapist
	Habilitation services	5% coinsurance	15% coinsurance	
	Skilled nursing care	5% coinsurance	15% coinsurance	None
	Durable medical equipment	5% coinsurance	15% coinsurance	None
	Hospice services	5% coinsurance	15% coinsurance	None
If your child needs dental or eye care	Children's eye exam	$10 copay/visit	$45 copay/visit	Coverage limited to one exam/year.
	Children's glasses	$10 copay for lenses	$30 copay for single vision $50 copay for lined bifocal $65 copay for lined trifocal	Coverage limited to one pair of glasses/year. Frames covered to $130 maximum for network

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)	
			$100 copay for lenticular	providers and a $70 maximum for out-of-network providers
	Children's dental check-up	20% coinsurance	20% coinsurance	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
- Cosmetic Surgery
- Infertility Treatment
- Long Term Care
- Weight loss programs

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

- Bariatric Surgery, when medically necessary
- Chiropractic Care
- Dental Care (Adult)
- Hearing Aids, once every 3 years; $1,000 maximum
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing when medically necessary or not custodial care
- Routine eye care (Adult)
- Routine Foot Care if medically necessary

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's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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: 216.267-3344 or 888.424.7488 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 216-267-3344 or 888-424-7488.][Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 216-267-3344 or 888-424-7488.][Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 216-267-3344 or 888-424-7488.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 216-267-3344 or 888-424-7488.]

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	$150
Specialist copayment	$10
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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	$150
Copayments	$20
Coinsurance	$625
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$855

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

The plan's overall deductible	$150
Specialist copayment	$10
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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*	$150
Copayments	$80
Coinsurance	$745
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,031

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

The plan's overall deductible	$150
Specialist copayment	$10
Hospital (facility) coinsurance	5%
Other coinsurance	5%

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	$1,941

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$150
Copayments	$150
Coinsurance	$68
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$368

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