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, visit www.hdplus.com or call 1-800-549-9114. 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.dol.gov/ebsa/healthreform or call 1-800-549-9114 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	TCHHN/Anthem/Out of Network Deductible is determined by the Network. Employee Only: **$500 / $1,000 / $1,000** Employee + 1: **$750 / $1,500 / $1,500** Family: **$1,000 / $2,000 / $2,000**	Generally, you must pay for all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	**Yes.** Office visits, urgent care services, preventive care if received by a network provider. Deductible also does not apply to prescription drugs.	This plan covers some items and services 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?	Out-of-pocket limit is determined by the Network. Employee Only: **$3,000 / $6,000 / $6,000** Employee + 1: **$6,000 / $9,000 / $9,000** Family: **$9,000 / $12,000 / $12,000** No individual will exceed $8,150 for a Network provider.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	**Yes.** Premiums, balance-billing charges (unless balance billing is prohibited), and health care this plan does not 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 for a list of network providers.	You pay the least if you use a provider in The Christ Hospital Health Network. You pay more if you use a provider in the Anthem 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
		The Christ Hospital Health Network (TCHHN)	Anthem Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment/visit	PCP: $50 copayment/visit Pediatrician: $25 copayment/visit	50% coinsurance	Coverage is also available for telemedicine visits. Deductible does not apply to TCHHN and Anthem network providers.
	Specialist visit	$45 copayment/visit	$65 copayment/visit	50% coinsurance	
	Preventive care/screening/ immunization	No Charge	No Charge	Not Covered	Deductible does not apply to TCHHN and Anthem network providers. You may have to pay for services that aren't preventive. 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)	20% coinsurance	30% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		The Christ Hospital Health Network (TCHHN)	Anthem Network Provider	Out-of-Network Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from Optum Rx by visiting www.optumrx.com or calling 1-855-312-7412.	Generic drugs	**Retail:** 25% coinsurance ($10 minimum copayment, $40 maximum copayment) **Mail Order:** 25% coinsurance ($21 minimum copayment, $105 maximum copayment)		50% coinsurance after Network Provider copayment	Copayments for prescriptions filled at a retail pharmacy for up to a 30 day supply. A 90-day supply is available for 3 copayments. Prescriptions filled through mail order are available for up to a 90 day supply. Certain preventive drugs are available at no cost to you. Additionally, certain drugs require prior authorization. Contact Optum Rx for additional information. Infertility medications have an annual maximum of $2,500, per individual (paid by the plan). This maximum does not accumulate towards the medical plan.
	Preferred brand drugs	**Retail:** 25% coinsurance ($35 minimum copayment, $75 maximum copayment) **Mail Order:** 25% coinsurance ($60 minimum copayment, $205 maximum copayment)		50% coinsurance after Network Provider copayment	
	Non-preferred brand drugs	**Retail:** 50% coinsurance ($55 minimum copayment, $100 maximum copayment) **Mail Order:** 50% coinsurance ($150 minimum copayment, $300 maximum copayment)		50% coinsurance after Network Provider copayment	
	Specialty drugs	**Retail (1-30 day supply):** 50% coinsurance ($100 minimum copayment, $225 maximum copayment) **Retail (31-90 day supply):** 50% coinsurance ($200 minimum copayment, $450 maximum copayment)		50% coinsurance after Network Provider copayment	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	Same as TCHHN	Same as TCHHN	Non-emergency services are not covered.
	Emergency medical transportation	20% coinsurance	Same as TCHHN	Same as TCHHN	Non-emergency services are not covered.
	Urgent care	$30 copayment/visit	$50 copayment/visit	50% coinsurance	Deductible does not apply to TCHHN and Anthem network providers.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization is required. If you do not receive a Preauthorization, benefits may be reduced.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		The Christ Hospital Health Network (TCHHN)	Anthem Network Provider	Out-of-Network Provider	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $25 copayment/visit Other Outpatient: 20% coinsurance	Office Visit: $50 copayment/visit Other Outpatient: 30% coinsurance	50% coinsurance	Deductible does not apply to TCHHN and Anthem network providers for office visits.
	Inpatient services	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization is required. If you do not receive a Preauthorization, benefits may be reduced.
If you are pregnant	Office visits	$45 copayment/visit	$65 copayment/visit	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization is required. If you do not receive a Preauthorization, benefits may be reduced.
	Rehabilitation services	20% coinsurance	30% coinsurance	50% coinsurance	Speech therapy, physical therapy, occupational therapy, and cognitive therapy are limited to 30 visits per calendar year.
	Habilitation services	20% coinsurance	30% coinsurance	50% coinsurance	Same limitations as rehabilitation services.
	Skilled nursing care	20% coinsurance	30% coinsurance	50% coinsurance	Limited to 180 days per calendar year. Preauthorization is required. If you do not receive a Preauthorization, benefits may be reduced.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		The Christ Hospital Health Network (TCHHN)	Anthem Network Provider	Out-of-Network Provider	
	Durable medical equipment	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization is required for items over $750. If you do not receive a Preauthorization, benefits may be reduced. Limited to 1 wheelchair every 3 years, 1 motorized wheelchair per lifetime, 1 in-shoe orthotic (per foot) every 3 years, and 4 compression stockers each year.
	Hospice services	20% coinsurance	30% coinsurance	50% coinsurance	Preauthorization is required. If you do not receive a Preauthorization, benefits may be reduced.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Not Covered	Limited to 1 exam per calendar year.
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	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
- Cosmetic surgery
- Dental care
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot 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
- Chiropractic care
- Infertility treatment
- Private duty nursing (inpatient only)
- Routine eye care

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: 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**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the 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 1-800-549-9114.

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 (TCHHN) $500**
- **Specialist copayment (TCHHN) $45**
- **Hospital (facility) coinsurance (TCHHN) 20%**
- **Other coinsurance (TCHHN) 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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$60
Coinsurance	$2,440
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

- **The plan's overall deductible (TCHHN) $500**
- **PCP copayment (TCHHN) $25**
- **Hospital (facility) coinsurance (TCHHN) 20%**
- **Other coinsurance (TCHHN) 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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$600
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,200**

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

- **The plan's overall deductible (TCHHN) $500**
- **Specialist copayment (TCHHN) $45**
- **Hospital (facility) coinsurance (TCHHN) 20%**
- **Other coinsurance (TCHHN) 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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

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