



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.cookmedicalclaims.com or call 1-800-593-2080. 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.cookmedicalclaims.com or call 1-800-593-2080 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Network : \$1,700 Individual / \$3,400 Family Out-of-Network : \$1,700 Individual / \$3,400 Family Copayments don't apply to the deductible.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Network preventive care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. 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 other specific deductibles .	None
What is the out-of-pocket limit for this plan ?	For network providers , there is a \$2,000 individual / \$4,000 family out-of-pocket limit . There is no limit 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 , the overall family out-of-pocket limit must be met.

What is not included in the out-of-pocket limit ?	Premiums, balance-billing charges (unless balance-billing is prohibited), health care this plan doesn't cover, adult dental, vision, family planning, out-of-network charges, amounts reimbursed under the prescription drug specialty care program, and penalties for failure to obtain preauthorization .	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 1-800-810-2583 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 these services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from the plan .



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 /visit	Not covered	Co-pay covers lab work, minor surgery, and x-rays in physician's office.
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening /immunization	No charge	40% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cookmedicalclaims.com .	Generic drugs	20% coinsurance	20% coinsurance	None
	Preferred brand drugs	20% coinsurance	20% coinsurance	None
	Non-preferred brand drugs	20% coinsurance	20% coinsurance	None
	Specialty drugs	20% coinsurance	20% coinsurance	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization required for most outpatient surgeries or surgeries are not covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization required for most outpatient surgeries or surgeries are not covered.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transport	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required for coverage.

* For more information about limitations and exceptions, see the Clinic Plan Summary or policy document at www.cookmedicalclaims.com.

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 a hospital stay	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization required for coverage.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required for coverage.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization required for coverage.
	Rehabilitation services	20% coinsurance	40% coinsurance	None
	Habilitation services	20% coinsurance	40% coinsurance	None
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization required for coverage.
	Durable medical equipment	20% coinsurance	40% coinsurance	Some equipment must be preauthorized for coverage.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization required for coverage.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Coverage available separate from health plan.
	Children's glasses	Not covered	Not covered	Coverage available separate from health plan.
	Children's dental check-up	Not covered	Not covered	Coverage available separate from health plan.

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
- Non-emergency care when traveling outside the U.S.
- Long-term care
- Weight loss programs
- Routine foot care

* For more information about limitations and exceptions, see the Clinic Plan Summary or policy document at www.cookmedicalclaims.com.

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

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|--|-------------------------|----------------------------|
| • Chiropractic care | • Bariatric surgery | • Private duty nursing |
| • Cosmetic surgery to repair an injury or congenial deformity or to restore normal body function | • Dental care (adult) | • Routine eye care (adult) |
| | • Infertility treatment | • Hearing aids |

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 (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: Cook Group Plan Administrator, Cook Group Incorporated, P.O. Box 1608, Bloomington, IN 47402, 1.800.593.2080 or Department of Labor's Employee Benefits 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 1.800.593.2080.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.800.593.2080.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1.800.593.2080.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1.800.593.2080.

—————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	\$1700
■ Specialist coinsurance	20%
■ 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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,700
Copayments	\$0
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$15
The total Peg would pay is	\$2,015

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1700
■ Specialist coinsurance	20%
■ 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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,700
Copayments	\$0
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$2,000

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1700
■ Specialist coinsurance	20%
■ 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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,700
Copayments	\$0
Coinsurance	\$220
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,920

The Clinic [Plan](#) would be responsible for the other costs of these EXAMPLE covered services.