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 call 513-861-4800. 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.cms.gov/cciio/index.html or call 513-861-4800 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $500 individual /$1,500 family; for out-of-network providers $1,500 individual/ $4,500 family. **Certain Out-of-Network claims are treated as In-Network claims as required by No Surprises Act.*	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 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. 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?	Yes. Dental - $50 individual / $150 family.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Medical - For network providers $1,400 individual/ $4,200 family; for out-of-network providers $3,000 individual/ $9,000 family. Prescription – For network $5,650 individual / $10,100 family. **Certain Out-Of-Network claims are treated as In-Network claims as required by No Surprises Act.*	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for non-compliance, charges over allowed amount, 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 or call 513-861-4800 for a list of network providers. **Out-of-Network providers may be treated as In-Network providers as required by No Surprises Act.*	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	$35 copay/per visit; deductible does not apply	40% coinsurance	Online Virtual Doctor Office Visits through Anthem LiveHealth Online at no charge to you.
	Specialist visit	$50 copay/per visit; deductible does not apply	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 needed 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	Preauthorization may be required for some tests.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.savrx.com.	Level 1 Drugs	$10 copay/prescription (retail); $20 copay/prescription (mail order)	30% coinsurance; mail order not covered	30-day supply for Retail Pharmacy. 90-day supply for Mail Order. Coverage may be subject to prior authorization and step-therapy requirements.
	Level 2 Drugs	$35 copay/prescription (retail); $70 copay/prescription (mail order)	30% coinsurance; mail order not covered	30-day supply for Retail Pharmacy. 90-day supply for Mail Order. Coverage may be subject to prior authorization, step-therapy, and mandatory generic requirements.
	Level 3 Drugs	$60 copay/prescription (retail); $120 copay/prescription (mail order)	30% coinsurance; mail order not covered	30-day supply for Retail Pharmacy. 90-day supply for Mail Order. Coverage may be subject to prior authorization, step-therapy, and mandatory generic requirements.
	Specialty drugs	20% coinsurance	30% coinsurance; mail order not covered	Maximum copayment $120 in-network. 30-day supply for Retail Pharmacy. 90-day supply for Mail Order. Coverage may be subject to prior authorization and step-therapy requirements.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Precertification is required.

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)	
	Physician/surgeon fees	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Precertification is required.
If you need immediate medical attention	Emergency room care	$250 copay; deductible does not apply	$250 copay; deductible does not apply unless otherwise required by No Surprises Act	If you are admitted to the hospital, the copay will be waived.
	Emergency medical transportation	20% coinsurance	20% coinsurance unless otherwise required by No Surprises Act	None
	Urgent care	$100 copay/visit; deductible does not apply	$100 copay/visit; deductible does not apply unless otherwise required by No Surprises Act	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Precertification is required.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit; deductible does not apply	40% coinsurance unless otherwise required by No Surprises Act	The first six (6) outpatient visits per condition with a TriHealth EAP Provider are covered at no charge.
	Inpatient services	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Precertification is required.
If you are pregnant	Office visits	$35 copay/visit (primary care) or $50 copay/visit (specialist); deductible does not apply	40% coinsurance unless otherwise required by No Surprises Act	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). Benefits for employee or spouse only.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	
	Childbirth/delivery facility services			
If you need help recovering or have other	Home health care	20% coinsurance	40% coinsurance	Precertification is required.
	Rehabilitation services	$35 copay/visit	40% coinsurance	Limit of 50 visits/calendar year for speech therapy.

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)	
special health needs	Habilitation services	$35 copay/visit	40% coinsurance	Speech therapy not covered.
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification is required. Coverage is limited to 30 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	Precertification may be required. Coverage is limited to 21 days per lifetime.
If your child needs dental or eye care	Children's eye exam	$20 copay	You will be reimbursed up to $42	Limited to one exam per calendar year.
	Children's glasses	$20 copay for most lenses, $130 allowance for frames	You will be reimbursed up to $40-$80 for lenses (depending on type), and up to $45 for frames	Limited to one set per calendar year.
	Children's dental check-up	No charge	No charge	Calendar year maximum benefit of $750 for dental care.

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.)

- Bariatric Surgery (unless to address morbid obesity)
- Cosmetic surgery
- Hearing Aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss program

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

- Acupuncture, if medically necessary and performed in lieu of generally accepted anesthesia practices
- Dental Care
- Chiropractic care, limited to $3,000 per covered person, per calendar year
- Routine Eye Care (Adult)

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: U.S. Department of Health and Human Services at 1-877-267-2323 ext. 61565. 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 Fund Office at 513-861-4800.

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: **N/A**

*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** **$500**
- **Specialist copay** **$50**
- **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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,460**

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

- **The plan's overall deductible** **$500**
- **Specialist copay** **$50**
- **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**

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** **$500**
- **Specialist copay** **$50**
- **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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$700
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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