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 the Plan Sponsor at (859) 858-2285. 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 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000**/individual or **$2,000**/family for Lexington Clinic Providers. **$2,000**/individual or **$4,000**/family for Network Providers. **$6,000**/individual or **$12,000**/family for Out-of-Network Providers.	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. *Deductible amounts accumulate jointly for Lexington Clinic Providers and Network Providers.*
Are there services covered before you meet your deductible?	Yes. In-network 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?	**$4,000**/individual or **$8,000**/family for Lexington Clinic Providers. **$4,000**/individual or **$8,000**/family for Network Providers. **$8,000**/individual or **$16,000**/family for Out-of-Network Providers. Separate Pharmacy Out-of-Pocket Limit: **$2,600**/individual or **$5,200**/family.	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. *The Maximum Out-of-Pocket limits accumulate jointly for Lexington Clinic Providers and Network Providers.*
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties, Out-of-Network transplant services, and health care this plan	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

	doesn't cover.	
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call ARC Administrators at 1-877-309-2955 for a list of network providers.	You pay the least if you use a provider in Lexington Clinic. You pay more if you use a network provider. 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
		Lexington Clinic Provider (You will pay the least)	Network Provider	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	No charge	$30 copay/office visit (deductible does not apply)	40% coinsurance	Additional costs may apply based on services provided.
	Specialist visit	No charge	$60 copay/office visit (deductible does not apply)	40% coinsurance	
	Preventive care/screening/ immunization	No charge	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)	No charge	20% coinsurance	40% coinsurance	Diagnostic testing during an in-network office visit is covered under the office visit copay.
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	40% coinsurance	Precertification is required.

*For more information about limitations and exceptions, see the plan or policy document.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Lexington Clinic Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs (Tier 1)	Not covered	Retail - $8 copay/ prescription Mail Order/90-day retail - $16 copay/ prescription	Not covered	CVS Caremark Network Pharmacies are covered. Pharmacy Out-of-Pocket Maximum: **$2,600**/individual or **$5,200**/family Your plan uses a preferred drug list which identifies the status of covered drugs. Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Preferred brand drugs (Tier 2)	Not covered	Retail - $35 copay/ prescription Mail Order/90-day retail - $70 copay/ prescription	Not covered	
	Non-preferred brand drugs (Tier 3)	Not covered	Retail - $50 copay/ prescription Mail Order/90-day retail - $100 copay/ prescription	Not covered	
	Specialty drugs (Tier 4)	Not covered	20% coinsurance, (maximum of $100 copay for Generic drugs)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	40% coinsurance	Precertification is required.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	40% coinsurance	----------None----------
If you need immediate medical attention	Emergency room care	Not applicable	$250 copay/visit (deductible does not apply)	$250 copay/visit (deductible does not apply)	Copayment waived if admitted. Non-emergent care is not covered.
	Emergency medical transportation	Not applicable	20% coinsurance	Covered as In-Network	Precertification is required for non-emergent ambulance.
	Urgent care	$50 copay/visit (deductible does not apply)	$75 copay/visit (deductible does not apply)	$75 copay/visit (deductible does not apply)	Additional costs may apply based on services provided.

*For more information about limitations and exceptions, see the plan or policy document.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Lexington Clinic Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	0% coinsurance	40% coinsurance	Precertification is required.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	40% coinsurance	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	$30 copay/office visit (deductible does not apply) or 20% coinsurance (based on place of service)	40% coinsurance	----------None----------
	Inpatient services	Not applicable	0% coinsurance	40% coinsurance	Precertification is required.
If you are pregnant	Office visits	No charge	$800 copay for maternity (deductible does not apply)	40% coinsurance	Maternity services are covered under one copay if utilizing a Network Provider. 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	0% coinsurance	$800 copay for maternity (deductible does not apply)	40% coinsurance	
	Childbirth/delivery facility services	Not applicable	$800 copay for maternity (deductible does not apply)	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	Not applicable	20% coinsurance	40% coinsurance	Precertification is required. Limited to 100 visits/year combined Network & Out-of-Network.
	Rehabilitation services	Office Visits: No charge Outpatient Services: 10%	$30/$60 copay/ office visit (deductible does not apply) or 20% coinsurance (based	40% coinsurance	Precertification is required for physical therapy, occupational therapy, speech therapy, and cardiac rehabilitation. Outpatient therapy limits are combined

*For more information about limitations and exceptions, see the plan or policy document.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Lexington Clinic Provider (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
		coinsurance	on place of service)		Network & Out-of-Network: Physical Therapy: 20 visits/year Manipulation Therapy: 15 visits/year Occupational Therapy: 20 visits/year Speech Therapy: 20 visits/year Cardiac Rehabilitation: No visit limits Pulmonary Rehabilitation: No visit limits
	Habilitation services	Office Visits: No charge Outpatient Services: 10% coinsurance	$30/$60 copay/ office visit (deductible does not apply) or 20% coinsurance (based on place of service)	40% coinsurance	
	Skilled nursing care	Not applicable	0% coinsurance	40% coinsurance	Precertification is required. Limited to 90 days/year combined Network & Out-of-Network.
	Durable medical equipment	10% coinsurance	20% coinsurance	40% coinsurance	Precertification is required.
	Hospice services	Not applicable	No charge	No charge	Precertification is required.
If your child needs dental or eye care	Children's eye exam	No charge	$30/$60 copay/office visit (deductible does not apply)	40% coinsurance	Coverage limited to one exam/year with an optometrist or ophthalmologist.
	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 (Adult)
- Infertility Treatment
- Long-Term Care
- 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
- Hearing Aids
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Eye Care (Adult)

*For more information about limitations and exceptions, see the plan or policy document.

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: ARC Administrators at 1-877-309-2955, the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the 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: ARC Administrators at 1-877-309-2955 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Kentucky Department of Insurance, Consumer Protection Division at 1-800-595-6053 or http://healthinsurancehelp.ky.gov.

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 1-877-309-2955.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-309-2955.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-309-2955.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-309-2955.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

*For more information about limitations and exceptions, see the plan or policy document.

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	$2000
Specialist copayment	$60
Hospital (facility) coinsurance	0%
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$800**

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

The plan's overall deductible	$2000
Specialist copayment	$60
Hospital (facility) coinsurance	0%
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$400
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,400**

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

The plan's overall deductible	$2000
Specialist copayment	$60
Hospital (facility) coinsurance	0%
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,150**

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