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?	$500 per individual or $1,000 per family for network services. Separate $500/individual and $1000/family deductibles for out-of-network services. No more than $500 per person counts towards the family deductible. In-network preventive care, dental or vision care and prescription drugs are not subject to these deductibles. Dental and vision care, prescription drugs, copays, and second and third opinions cannot be used to satisfy deductibles.	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, 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, specialist care, and primary 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. There is a $300 family deductible for prescription drug coverage. No other specific deductibles.	You must pay all 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?	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

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

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 Cook Insurance Dept. at 1-800-593-2080 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.

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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	$15 copay/visit and 20% coinsurance for other outpatient services; the deductible will apply	40% coinsurance	Co-pay does not cover lab work, minor surgery and x-rays in physician's office.
	Specialist visit	$15 copay/visit and 20% coinsurance for other outpatient services; the deductible will apply	40% coinsurance	Co-pay does not cover lab work, minor surgery and x-rays in physician's office.
	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	50% coinsurance if the drug available in-network, but purchased out-of-network. Separate $300 annual family deductible. $100 coinsurance maximum for 30-day supply.
	Preferred brand drugs	20% coinsurance	20% coinsurance	
	Non-preferred brand drugs	20% coinsurance	20% coinsurance	
	Specialty drugs	20% coinsurance	20% coinsurance	
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	$100 co-pay; 20% coinsurance	$100 co-pay; 20% coinsurance	None.
	Emergency medical transport	20% coinsurance	20% coinsurance	None.
	Urgent care	$50 co-pay; 20%	$50 co-pay; 20%	None.

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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)	
		coinsurance	coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required for coverage.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization required for coverage.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 co-pay/office visit; 20% coinsurance for additional services	40% coinsurance	None.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required for coverage.
If you are pregnant	Office visits	$15 co-pay/office visit; 20% coinsurance for additional services	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		None.
	Skilled nursing care	20% coinsurance	40% coinsurance	None.
	Durable medical equipment	20% coinsurance	40% coinsurance	Some equipment must be preauthorized for coverage.
	Hospice services	20% coinsurance	40% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	No charge	See limitations and exceptions.	Out-of-network - $42 total allowance for an annual exam and $40/$60/$80 annual allowance for one pair of std. single/bifocal/trifocal lenses. $42 allowance for frames every 2 years.
	Children's eyeglass lenses	No charge	See limitations and exceptions.	In-network - $200 allowance for frames every 2 years.
	Children's dental check-up	No charge	No charge	Two per calendar year

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

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

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

- Chiropractic care
- Cosmetic surgery to repair an injury or congenial deformity or to restore normal body function
- Bariatric surgery
- Dental care (adult)
- Infertility treatment
- Private duty nursing
- Routine eye care (adult)
- 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 Health 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? This plan does provide Minimum Essential Coverage.
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 the Minimum Value Standards? This plan does meet the Minimum Value Standards.
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, kwiijigo holne' 1.800.593.2080.

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 Traditional Plan Summary or policy document at www.cookmedicalclaims.com.

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 copayment	$15
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	$642
Copayments	$0
Coinsurance	$1,358
What isn't covered	
Limits or exclusions	$30
The total Peg would pay is	**$2,030**

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 copayment	$15
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	$434
Copayments	$90
Coinsurance	$1,137
What isn't covered	
Limits or exclusions	$51
The total Joe would pay is	**$1,712**

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

The plan's overall deductible	$500
Specialist copayment	$15
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	$130
Coinsurance	$228
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$858**

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