



NEW EMPLOYEE PACKET 2021

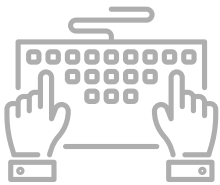


NEW EMPLOYEE CHECKLIST



○ Enroll Within 30 Days

You must complete your benefit elections within 30 days of your first day of employment. If you do not, you must wait until Open Enrollment, in the fall, to elect or make changes to your benefits. Restrictions may apply.



○ 4myBenefits - Enroll Online

The City of Cincinnati partners with 4myBenefits, a leader in online benefits administration, to make it easy for you to understand your benefits, make decisions, and enroll, all without any paper. **Log on to www.COCBenefits.com or call 1-866-477-1604 to enroll today.** Once you log in, the site will display your personal benefit options. You can even use your mobile device to enroll. **See Page 4 for details.**

See Page 4 for Login Instructions >>



○ Health Lifestyles - Earn Money

Don't forget to log into Healthy Lifestyles - the City's wellness program where you can earn up to \$300 per person each year to spend on out-of-pocket healthcare expenses. **See page 24 for additional details.**



○ Required Documentation

If you plan on covering your Spouse, Equal Partner or Children, you must provide supporting documentation in order to cover them on the City's benefits. Get your benefits faster by collecting your documents before you enroll. 4myBenefits will prompt to you upload the documents once you make your benefit selections.



○ Spousal Surcharge

If you are a NON-REPRESENTED employee you will be charged a \$100 monthly spousal surcharge if your spouse/equal partner has access to other group healthcare (through an employer or a non-Medicare, Medicaid, or Social Security retirement system) and you enroll them on a City health plan. Please make sure you review the Health Reimbursement Arrangement (HRA). It may be an option for you and your family while also helping you avoid the surcharge. **See page 13 for details.**



○ Voya Benefits - No Medical Questions

As a new employee, you are eligible to participate in the City's Voluntary Life Insurance and Long-Term Disability Insurance. Now is the time to enroll in these programs because there will be no medical underwriting (up to the guaranteed amounts) during your first 30 days of employment.

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BENEFITS at a GLANCE*

		COUNCIL MEMBERS	NON-REPRESENTED	BUILDING TRADES	FIRE	CODE	AFSCME	POLICE
80/20 HEALTH PLAN & PRESCRIPTION	Carriers	Anthem						
	Monthly Premium†	Single: \$63.83 Family: \$1,346.14				Single: \$60.83 Family: \$182.94		
HIGH DEDUCTIBLE HEALTH PLAN WITH HEALTH SAVINGS ACCOUNT & PRESCRIPTION	Carriers	Anthem and Custom Design Benefits: www.customdesignbenefits.com or 513.598.2929						
	Monthly Premium‡	Single: \$29.40 Family: \$1,200.61				Single: \$26.40 Family: \$79.40		
HEALTH REIMBURSEMENT ARRANGEMENT	Carrier	Catilize Health: CinciiHRA@catilizehealth.com , 877.872.4232 or CinciiHRA@catilizehealth.com						
	Annual Reimbursement	Maximum Annual Premium Reimbursement: \$5,000/Single or \$10,000/Family + Maximum Annual Out-of-Pocket Claims Payment: \$8,150/Single or \$16,300/Family						
DENTAL	Carrier	Superior Dental Care						
	Monthly Premium		\$0		Single: \$2.00 Family: \$2.00	\$0	AFSCME Union	Police Union
VISION	Carrier	EyeMed						
	Monthly Premium	\$0						AFSCMEcareplan.com
FLEXIBLE SPENDING ACCOUNTS	Carrier	Custom Design Benefits: www.customdesignbenefits.com or 513.598.2929						
	FSA Types	Health, Dependent Care & Transportation Expense Reimbursement Account						
LIFE & LONG-TERM DISABILITY INSURANCE	Carrier	VOYA				VOYA	AFSCME Union VOYA	
	Plan Types	Voluntary LTD Voluntary Life	Basic Life Voluntary LTD Voluntary Life		IAFF	Basic Life Voluntary LTD Voluntary Life	AFSCME Life Voluntary Life Voluntary LTD	FOP FOP69.org
	Monthly Premium	Visit COCBenefits.com for details	Basic Life: \$0 (City paid) Voluntary: Visit COCBenefits.com for details			Basic Life: \$0 (City paid) Voluntary: Visit COCBenefits.com for details	Visit COCBenefits.com or AFSCMECarePlan.com for details	
CRITICAL ILLNESS & ACCIDENT	Carrier	VOYA						
	Monthly Premium	Visit COCBenefits.com for details. Critical Illness rates are locked-in at the age in which you initially enroll.						

*All rates and coverage are subject to union contract negotiations. †80/20 Equal Partner rates available on [page 10](#). ‡HDHP Equal Partners rates available on [page 12](#).

CITY of CINCINNATI ENROLLMENT INSTRUCTIONS

Choose Your Benefits:

You have 30 days from your first day to elect your benefits. If you don't, you must wait until the next Open Enrollment — usually in the fall. The only exception is if you have a Qualifying Life Event, such as marriage, divorce, birth, death, custody, etc. You must login within 30 days of the Qualifying Life Event to make changes. If you don't, you must also wait until the next Open Enrollment.

ENROLL ONLINE!

Enjoy the convenience of 24/7 enrollment at your fingertips on any device.

Website: www.COCBenefits.com

Username:

- Your username format is COC plus your Employee ID number. (example: COC12345).

Password:

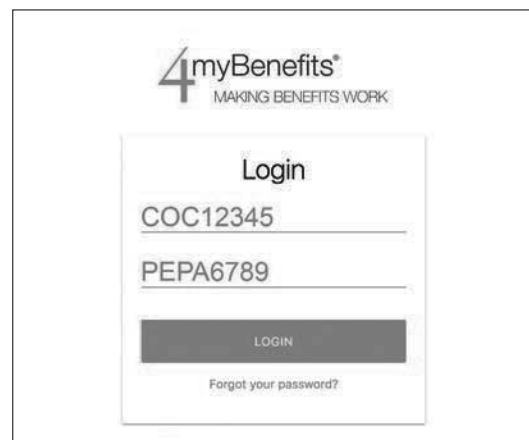
- Your initial password will be:
 - The first 2 letters of your first name (all upper case) + the first 2 letters of your last name (all upper case) + the last 4 numbers of your social security number

*Example for Peter Parker would be:
PEPA6789 (this is case sensitive).*

- You will be prompted to change your password once you log in. Your new password must be at least 8 characters with 1 letter and 1 number.
- You will be prompted to change your password once you log in. Your new password must be **at least 8 characters with 1 letter and 1 number.**

Getting Started:

- Once you log in, click on “Get Started”.
- The screens will lead you through the steps from start to finish.
- Be sure to check out all the links to other documents and videos for details on each benefit to learn how they work.



Be prepared with all supporting documentation (birth certificate, marriage license, proof of financial interdependence, etc.) and social security numbers of any dependents you want to enroll on your plans. You must upload all supporting documentation before your enrollment is considered complete.

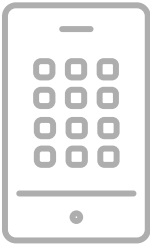
CITY of CINCINNATI ENROLLMENT INSTRUCTIONS Continued

OVER THE PHONE

Call: 866-477-1604

Hours: 8am to 5pm EST

Monday through Friday



Do you have questions or just need some assistance? You can enroll over the phone, or just call to ask any questions you or your family may have about your benefits.

A Benefits Call Center representative will walk you through your benefits and explain your coverage options. Be prepared with all supporting documentation (birth certificate, marriage license, proof of financial interdependence, etc.) and social security numbers of any dependents you want to enroll on your plans. You must submit all supporting documentation before your enrollment is considered complete.



ELIGIBILITY & SUPPORTING DOCUMENTATION

Employee & Family Eligibility

EMPLOYEES: Full time employees working 30 hours or more per week are eligible for the benefits outlined in this brochure.

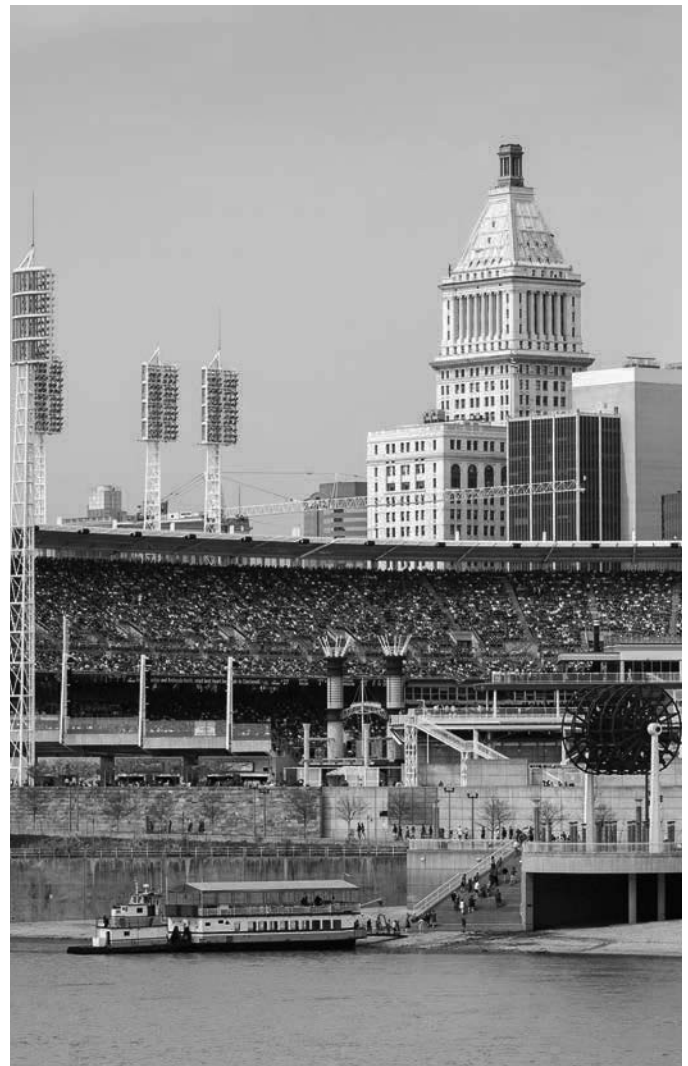
SPOUSE/EQUAL PARTNER: If you elect benefits for yourself, you may also elect benefits for your spouse/equal partner. Equal partners may be same sex or opposite sex. You will pay additional taxes to include your equal partner on the medical plan. If you get divorced or are no longer in an Equal Partner relationship, your spouse/EP is no longer eligible for benefits. You must disenroll them at www.COCBenefits.com within 30 days or you will be liable for any claims incurred.

If you are a NON-REPRESENTED employee you will be charged a \$100 monthly spousal surcharge if your spouse/equal partner has access to other group healthcare (through an employer or a non-Medicare, Medicaid, or Social Security retirement system) and you enroll them on a City health plan. Please make sure you review the Health Reimbursement Arrangement (HRA). It may be an option for you and your family while also helping you avoid the surcharge. **See page 13 for details.**

CHILDREN: If you elect benefits for yourself, you may also elect benefits for your children. Dependent children are you and your spouse/equal partner's: natural children, adopted children, step-children, children covered by a Qualified Medical Child Support Order, and children for whom you have legal guardianship. You will pay additional taxes to include your equal partner's children on the medical plan.

DISABLED CHILDREN: If your child is disabled or becomes disabled before turning age 26, they may be eligible for continued benefits. You **MUST** request and be approved for Continuation of Coverage from Anthem through the online enrollment tool at www.COCBenefits.com.

A NOTE ABOUT OTHER INSURANCE: If anyone covered under your City health plan is also covered under another insurance plan (including Medicare), you are required to report it to Anthem using the www.COCBenefits.com platform or by calling Anthem at 1.844.456.7112.



ELIGIBILITY & SUPPORTING DOCUMENTATION Continued

Supporting Documentation Required

To add SPOUSE: You must provide their social security number and a copy of a state issued marriage certificate. If you have been married for more than one year, you must also submit proof of financial interdependence; such as a copy of the front page of your most recent tax return or bank statement (with dollar amounts and account information marked out).

To add EQUAL PARTNER: You must provide their social security number and a notarized copy of the Affidavit of Declaration of Financial Interdependence with supporting documentation (see Affidavit for examples).

To add CHILDREN: You must provide their social security number and a copy of their birth certificate. If they are adopted or if you have legal guardianship, copies of court papers are required.

CHILD ELIGIBILITY BY PLAN	
MEDICAL	End of month they turn 26
SUPERIOR DENTAL CARE	End of 24th year
EYEMED	End of 24th year
AFSCME	Visit AFSCMEcareplan.com for details
FOP	Visit FOP69.org for details
CHILD LIFE INSURANCE	End of month they turn 26
ACCIDENT AND CRITICAL ILLNESS	End of month they turn 26

MEDICAL INSURANCE*

HEALTH PLAN COMPARISON

	TRADITIONAL 80/20 PLAN**	HIGH DEDUCTIBLE HEALTH PLAN WITH HEALTH SAVINGS ACCOUNT	HEALTH REIMBURSEMENT ARRANGEMENT
SINGLE MONTHLY PREMIUM	\$60.83 (\$729.92 annual)	\$26.40 (\$316.80 annual)	\$0
FAMILY MONTHLY PREMIUM	\$182.94 (\$2,195.28 annual)	\$79.40 (\$952.80 annual)	\$0
SINGLE IN-NETWORK DEDUCTIBLE	\$500	\$2,800	Single Coverage: Up to \$5,000 annual premium differential reimbursement + up to \$8,150 out of pocket expense. Family Coverage: Up to \$10,000 annual premium differential reimbursement + up to \$16,300 out of pocket expense
FAMILY IN-NETWORK DEDUCTIBLE	\$1,000	\$5,600	
SINGLE IN-NETWORK OUT-OF-POCKET MAXIMUM	\$2,000	\$3,400	
FAMILY IN-NETWORK OUT-OF-POCKET MAXIMUM	\$4,000	\$6,800	
CITY HSA CONTRIBUTION	\$0	Single: \$500 Family: \$1,000	
EMPLOYEE HSA CONTRIBUTION	\$0	Employee discretion, up to \$3,600 single / \$7,200 family annually	
POTENTIAL HEALTHY LIFESTYLES CONTRIBUTION	Single: \$300 +Spouse/ Equal Partner: \$600	Single: \$300 +Spouse/ Equal Partner: \$600	Only employee is eligible: \$300
PRESCRIPTION CO-PAYMENTS	\$10/\$20/\$30	Deductible then 20%	Part of out of pocket expense limits

*All rates and coverage are subject to union contract negotiations.

**Police & Fire hired Pre 2016 - \$300/\$600 In-Network deductible & \$1500/\$3000 In-Network Out-of-Pocket maximum.

You are not permitted to transfer between the HDHP & 80/20 Plans during the same plan year.

MEDICAL INSURANCE Continued*



TRADITIONAL 80/20 HEALTH PLAN

The City's 80/20 Plan is offered to full time City of Cincinnati employees. Both the medical and pharmacy portions of the 80/20 plan are now administered by Anthem.

AFSCME, CODE, BUILDING TRADES, NON-REPRESENTED, POLICE & FIRE (HIRED AFTER 2016)	80/20 IN NETWORK	80/20 NON-NETWORK
DEDUCTIBLE	\$500 Single \$1,000 Family	\$1,000 Single \$2,000 Family
COINSURANCE	20%	50%
OUT OF POCKET MAXIMUM	\$2,000 Single** \$4,000 Family**	\$4,000 Single** \$8,000 Family**
RX DRUGS (GENERIC/BRAND/NON-PREFERRED BRAND) RETAIL 30-DAY SUPPLY/MAIL ORDER 90-DAY SUPPLY	\$10/\$20/\$30 \$20/\$40/\$60	N/A

POLICE & FIRE (HIRED BEFORE 2016)	80/20 IN NETWORK	80/20 NON-NETWORK
DEDUCTIBLE	\$300 Single \$600 Family	\$600 Single \$1,200 Family
COINSURANCE	20%	50%
OUT OF POCKET MAXIMUM	\$1,500 Single** \$3,000 Family**	\$3,000 Single** \$6,000 Family**
RX DRUGS (GENERIC/BRAND/NON-PREFERRED BRAND) RETAIL 30-DAY SUPPLY/MAIL ORDER 90-DAY SUPPLY	\$10/\$20/\$30 \$20/\$40/\$60	N/A

* All rates and coverage are subject to union contract negotiations.

**Out-of-pocket maximum is the most you will pay out of pocket through the City's insurance plan. Please note that if you are utilizing a non-network provider, the provider may bill you directly for additional amounts not covered by Anthem that could exceed the stated out-of-pocket maximums.

You are not permitted to transfer between the HDHP & 80/20 Plans during the same plan year.

MEDICAL INSURANCE Continued*

TRADITIONAL 80/20 HEALTH PLAN



80/20 MONTHLY PREMIUMS (ALL EMPLOYEES)	
SINGLE	\$60.83
FAMILY	\$182.94

****If you are a NON-REPRESENTED employee, please be aware that a \$100 monthly spousal surcharge applies, in addition to the monthly premium, if your spouse has access to other group healthcare (through an employer or non-Medicare, Medicaid, Social Security retirement system) and you enroll them on a City health plan.**



Equal Partner Tax Implication

The Internal Revenue Service (IRS) does not recognize an equal partner as a tax-exempt dependent; therefore, the health insurance is viewed as a fringe benefit and must be declared by the employee for tax purposes. The monthly value of the fringe benefit varies based on your union group. The tax on the fringe benefit value will be deducted from the employee's paycheck on a bi-weekly basis.

2021 MONTHLY TAXABLE FRINGE BENEFIT VALUES FOR EQUAL PARTNERS					
TRADITIONAL 80/20 PLAN	NON-REP & BUILDING TRADES	AFSCME & POLICE	FIRE	COUNCIL MEMBERS	CODE
EMPLOYEE + EQUAL PARTNER	\$516.87	\$486.16	\$524.70	\$30.71	\$516.87
EMPLOYEE + EQUAL PARTNER'S CHILD(REN)	\$267.81	\$249.39	\$279.71	\$18.42	\$267.81
EMPLOYEE + EQUAL PARTNER + EMPLOYEE'S CHILD(REN)	\$559.96	\$529.25	\$560.59	\$30.71	\$559.96
EMPLOYEE + EQUAL PARTNER + EQUAL PARTNER'S CHILD(REN)	\$1,160.20	\$1,099.05	\$1,147.05	\$61.15	\$1,160.20
EMPLOYEE + EQUAL PARTNER + EMPLOYEE'S CHILD(REN) & EQUAL PARTNER'S CHILD(REN)	\$928.33	\$879.20	\$919.26	\$49.13	\$928.33

* All rates and coverage are subject to union contract negotiations.

You are not permitted to transfer between the HDHP & 80/20 Plans during the same plan year.

MEDICAL INSURANCE Continued

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)



What is a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)?

The High Deductible Health Plan (HDHP) is just like the City's traditional 80/20 health plan through Anthem, but with a higher deductible, lower premiums, and an added contribution to a Health Savings Account (HSA) that you can use for future medical expenses. You can also choose to make your own contributions to the HSA, which are pre-tax contributions.

Employees hired after January 1, 2016 will not have access to Retiree healthcare at the time they retire from the City. An HSA is one type of savings mechanism that can help you save for both current and future expenses. The money in the HSA belongs to you, the employee, even if you leave City employment.

Health Savings Account Details

An HSA is a bank account, administered by Custom Design Benefits (www.CustomDesignBenefits.com), created exclusively for those individuals on a high deductible health plan. It is funded via employer and employee pre-tax payroll contributions. The City of Cincinnati will contribute \$500 to those enrolled in single coverage and \$1,000 to family coverage, annually. Fifty percent is deposited in January, and 50% is deposited in July. Funds can be used to pay for qualified medical, dental and vision expenses.

The HSA works like a checking account. It is not pre-funded like the Flexible Spending Accounts. This means that the only money available to use is the money deposited to date. Additionally, the money in the account rolls over from year to year and belongs to you, even if you leave City employment. Please see the HSA FAQs at www.COCBenefits.com for more information.

How much can I contribute to my HSA?

The IRS limits how much you can contribute to your HSA on an annual basis. The 2021 limits are shown below and include both employee and employer contributions, as well as Healthy Lifestyle contributions if applicable. Please use the HSA worksheet found at www.COCBenefits.com to help you decide how much to contribute. You can change your HSA elections at any time, but be aware that there will be a delay before it is reflected on your paycheck.

2021 HSA CONTRIBUTION LIMITS	
SINGLE	\$3,600
FAMILY	\$7,200
CATCH UP (AGE 55+)	\$1,000

Could I be ineligible to contribute to an HSA?

Yes, there are situations in which you could be ineligible to contribute to an HSA. You are ineligible if you:

- Are enrolled in another non-qualified HDHP
- Can be claimed as a dependent on another person's tax returns
- Are enrolled in Medicare
- Your spouse is enrolled in a Healthcare FSA
- Are enrolled in another employer's Health Reimbursement Arrangement (HRA)

MEDICAL INSURANCE Continued

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) WITH HEALTH SAVINGS ACCOUNT (HSA)



All Employees	HDHP/HSA (IN NETWORK)
SINGLE DEDUCTIBLE	\$2,800
FAMILY DEDUCTIBLE	\$5,600
COINSURANCE	20%
OUT OF POCKET MAXIMUM	\$3,400 Single \$6,800 Family
RX DRUGS (GENERIC/BRAND/ NON-PREFERRED BRAND) RETAIL 30-DAY SUPPLY MAIL ORDER 90-DAY SUPPLY	Deductible then coinsurance

HDHP MONTHLY PREMIUMS (ALL EMPLOYEES)	
SINGLE	\$26.40
FAMILY	\$79.40

***If you are a NON-REPRESENTED employee, please be aware that a \$100 monthly spousal surcharge applies, in addition to the monthly premium, if your spouse has access to other group healthcare (through an employer or non-Medicare, Medicaid, Social Security retirement system) and you enroll them on a City health plan.*

Equal Partner Tax Implication

The Internal Revenue Service (IRS) does not recognize an equal partner as a tax-exempt dependent; therefore, the health insurance is viewed as a fringe benefit and must be declared by the employee for tax purposes. The monthly value of the fringe benefit varies based on your union group. The tax on the fringe benefit value will be deducted from the employee's paycheck on a bi-weekly basis.

2021 MONTHLY TAXABLE FRINGE BENEFIT VALUES FOR EQUAL PARTNERS				
HIGH DEDUCTIBLE HEALTH PLAN	NON-REP & BUILDING TRADES & CODE	AFSCME & POLICE	FIRE	COUNCIL MEMBERS
EMPLOYEE + EQUAL PARTNER	\$551.55	\$520.84	\$559.38	\$30.71
EMPLOYEE + EQUAL PARTNER'S CHILD(REN)	\$253.69	\$235.27	\$265.59	\$18.42
EMPLOYEE + EQUAL PARTNER + EMPLOYEE'S CHILD(REN)	\$570.25	\$539.54	\$570.88	\$30.71
EMPLOYEE + EQUAL PARTNER + EQUAL PARTNER'S CHILD(REN)	\$1,118.21	\$1,057.06	\$1,105.06	\$61.15
EMPLOYEE + EQUAL PARTNER + EMPLOYEE'S CHILD(REN) & EQUAL PARTNER'S CHILD(REN)	\$867.59	\$818.46	\$858.52	\$49.13

You are not permitted to transfer between the HDHP & 80/20 Plans during the same plan year.

DISCOVER THE HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

WHAT IS IT?

The Health Reimbursement Arrangement is a unique way to pay for health care. In this arrangement, eligible employees that switch to an alternate health care plan (spouse's employer plan, TriCare - active only, non-city retirement plan, etc.) can enroll in the city's HRA to help cover health care expenses.

It's like having TWO health care plans to cover medical expenses!



3 Reasons To Enroll

This unique approach to health care will save you money on health care expenses, especially unexpected medical costs. This approach makes health care more affordable for you and your family!



Save Money on Premiums and Medical Expenses



Generous Out-Of-Pocket Reimbursement



No Additional Cost

WHAT DOES HRA PAY FOR?

- Deductibles
- Co-Pays
- Co-Insurance
- Premium Differential

HOW MUCH WILL THE ACCOUNT COVER?

Premium Reimbursement (up to):



Single= \$5,000



Family= \$10,000

Out-Of-Pocket Expenses (up to):



Single= \$8,150



Family= \$16,300

SIDE BY SIDE COVERAGE

Here's what a medical situation could look like on the city's medical health coverage versus the city's HRA coverage.

Without the HRA

\$500 deductible
+ \$500 co-insurance
+ \$30 prescription co-pay

TOTAL = \$1,030



With the HRA & alternate plan

\$750 deductible
+ \$750 co-insurance
+ \$30 prescription co-pay

- \$1,530 HRA account pays

TOTAL YOU PAY = \$0

DON'T TAKE OUR WORD FOR IT -

See what employees are saying

"The first year, I know I saved a couple thousand dollars at least."

- Tammy

"Last year I probably saved... gosh, \$5,000 - \$10,000 easily."

- Mike

MEDICAL INSURANCE Continued

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)



What is the Health Reimbursement Arrangement?

The HRA is a voluntary program available to employees and dependents. You enroll in alternate group health coverage, such as through your spouse/equal partner's employer. You also enroll in the City HRA. The HRA reimburses out-of-pocket expenses related to your alternate group plan including the difference in premiums for the alternate group coverage.

Premium differentials can be reimbursed up to \$5,000 for single enrollment and \$10,000 for family enrollment. In addition, out of pocket expenses are paid up to a cap of \$8,150 for single enrollment and up to \$16,300 for family enrollment.

Eligibility and Enrollment

You enroll in an alternate group healthcare plan, such as your spouse/equal partner's employer's group health plan or Active Service Tricare, to be eligible for the HRA. Use the Flow Chart found at www.COCBenefits.com to help determine if you are eligible.

If you are not eligible to enroll on your spouse's plan, you can still enroll your dependents on your spouse or equal partner's alternate coverage, while enrolling in the employee only 8020 or HDHP plans. The HRA will cover their out of pocket expenses and premium differentials. Contact **COCBenefits at 877.477.1604** for more information.

Once you enroll in the HRA, you can switch to a City healthcare plan in the case of a "Qualifying Life Event" or at the next Open Enrollment period. A "Qualifying Life Event" is birth, death, marriage, divorce, custody, change in equal partner status, change in dependent

disability, change in other coverage, etc.

If you enroll in the HRA, your spouse/EP will not be eligible for reimbursement through the City's Healthy Lifestyles Program. You must submit proof of premium payments each year during Open Enrollment or your premium reimbursement will be terminated

What is Covered by the HRA Reimbursements?

The HRA only pays for expenses that are allowed under your other insurance plan. Your out-of-pocket medical expenses (co-payments, co-insurance, and deductibles) are paid up to a cap of \$8,150/yr for single enrollment and up to \$16,300/yr for family enrollment. Premium differentials can be reimbursed up to a cap of \$5,000/yr for single enrollment and \$10,000/yr for family enrollment. Refer to the Summary of Benefits and Coverage for the Integrated HRA located at www.COCBenefits.com for more details.

Dental & Vision are NOT included under the HRA.

If you enroll in the HRA, you may want to remain enrolled in the city or union sponsored dental and vision plans.

How does the HRA pay claims?

At most medical providers and pharmacies, present your alternate plan's insurance card. Then, present your HRA card and your out-of-pocket charges will be paid directly by Catilize Health (the City's HRA Administrator). No claims, receipts, or EOBs need to be submitted separately when the ID card is used. (**Please note** CVS, Walgreens and most Mail-Order Pharmacies will not accept secondary payors. You will have to pay for the prescription and then submit a paper claim form to J&K, to get reimbursed).

Questions? Contact the City's HRA Administrator, Catilize Health, at CinciiHRA@catilizehealth.com, 877- 872-4232 or CinciiHRA@catilizehealth.com for assistance with any eligibility, reimbursement or enrollment questions

Please note that if the other plan offers an HSA as part of their alternate health coverage, the other plan must agree to waive any contributions while you and/or your family is enrolled in the HRA. You may not contribute any amount to an HSA while you are enrolled in the HRA. Any contribution to an HSA while you are enrolled in the HRA make you ineligible to participate in the HRA.

DENTAL INSURANCE

CODE, Fire, Building Trades, Non-Represented

CODE, Fire, Building Trades, and **Non-Represented** employees are eligible for dental benefits through Superior Dental Care. For CODE, Building Trades and Non-Represented, the premium is paid by the City. The premium for Fire is \$2.00/month.

The Superior Dental Care plan offers both network and non-network benefits, however, you will pay less by staying in the network. To find a network provider visit www.SuperiorDental.com and click on "Find a Dentist."

Dependents are eligible for dental benefits through the end of the year in which they turn 24.

VISION INSURANCE

CODE, Fire, Building Trades, Non-Represented

CODE, Fire, Building Trades, and **Non-Represented** employees are eligible for vision benefits through EyeMed. The premium is paid by the City.

The EyeMed Vision plan offers both network and non-network benefits.

To find a network provider visit www.eyemedvisioncare.com and click on "Find a Provider." **These providers are typically included in the EyeMed SELECT network:**



SUPERIOR DENTAL CARE

MAXIMUM ANNUAL BENEFIT	\$1,200
DEDUCTIBLE (INDIVIDUAL/FAMILY)	\$50 / \$150
PREVENTIVE SERVICES	Covered in full
BASIC SERVICES	Deductible, then pay \$20%
MAJOR SERVICES	Deductible, then pay \$20%
ORTHODONTIA (UP TO AGE 19)	50% up to \$1,200

EYEMED

MAXIMUM ANNUAL BENEFIT	\$100 per covered member per year
VISION EXAM	\$10 copay, once per 12 months
STANDARD PLASTIC LENSES	
SINGLE	\$0 copay
BI-FOCAL	\$10 copay
TRI-FOCAL	\$45 copay
All once per 12 months	
FRAMES	\$50 allowance, once per 24 months
CONTACTS	\$100 allowance
LENS UPGRADES	Discounts

ADDITIONAL EYEMED DISCOUNTS

- Amplifon Hearing Health Care hearing aid discount program: <https://hearing.eyemed.com>
- LASIK vision correction discount program: <https://www.eyemedlasik.com>

AFSCME CARE PLAN



AFSCME Dental, Vision, and Life Insurance Benefits

AFSCME employees receive dental, vision, life insurance, and additional benefits through their union. For information on the AFSCME Care Plan, go to www.AFSCMECarePlan.com or contact AFSCME at 513.641.4111.

Additional AFSCME Benefits

Hearing Aides: for more information go to AFSCMECarePlan.com or contact AFSCME at 513-641-4111

Teladoc: available at no cost, \$0 copay, saving you and your eligible dependents both time and money!



How to start:

1. Set up over the phone in 10 minutes:
Call 1.800.835.2362
2. Download the mobile app:
Visit www.Teladoc.com/Mobile
3. Got to Member.Teladoc.com/Registration
 - a. Complete personal information fields, click continue
 - b. Select AFSCME Care Plan
 - c. Create username and password
 - d. Fill out brief medical history

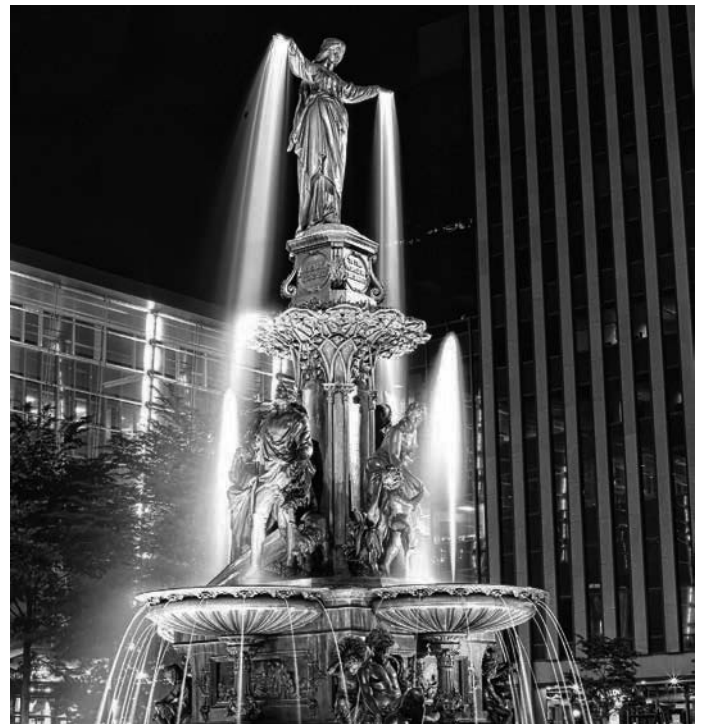
FOP BENEFITS



Police Dental and Vision Benefits

Police employees receive dental and vision plus additional benefits through their union. For information on the FOP benefits, please contact the FOP at 513.381.2550.

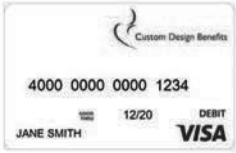
www.FOP69.org



FLEXIBLE SPENDING ACCOUNTS



A Flexible Spending Account (FSA) is a city-sponsored savings account that allows you to save money for certain qualified expenses on a pre-tax basis. The City offers three types of Flexible Spending Accounts through Custom Design Benefits — Medical, Dependent Care, and Transportation Expense Reimbursement Account. You can use FSA funds to pay for your qualified medical, dependent care, and parking and transit expenses.



How it Works

Estimate your out-of-pocket expenses for the current plan year. Then select the amount that you want to deposit in your FSA based on your estimated expenses. Throughout the year, your election will be deducted from your paycheck on a pre-tax basis. For medical and dependent care, you should always estimate conservatively because if you do not use your money in the allotted time period, you lose it.

The IRS determines what types of expenses are allowed. This list changes, so it is important that you check current lists to determine eligibility at www.irs.gov.

Medical FSA for 80/20 participants

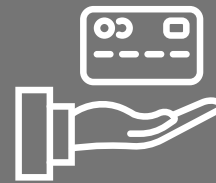
The Medical FSA allows you to set aside pretax dollars from your salary to pay for certain qualified health care expenses including medical, prescription, dental, and vision out-of-pocket expenses for you and your dependents.

You can access the funds upon



enrollment, using the debit card that will be mailed to you when you open the account. Remember, you may need to submit receipts to Custom Design Benefits for certain debit card purchases. This can be done easily through their new mobile app!

The IRS limits the amount you can contribute to a medical FSA. **The 2021 contribution limit is \$2,750.** Contributions made during 2021 must be used for health care expenses incurred between January 1, 2021 and March 15, 2022. Claims documentation



USE IT OR LOSE IT! The IRS does not allow funds from your current Medical & Dependent Care FSA plan year to be carried over to the next plan year. Any funds left over after the March 31st deadline will be forfeited. PLEASE ESTIMATE CONSERVATIVELY AND NOTE THE DEADLINE ON YOUR CALENDAR.

must be submitted by March 31, 2022 to get reimbursed. **If claims are not submitted by the deadline, you will forfeit any money remaining in your FSA account. If you leave the City, you are only reimbursed for expenses incurred prior to your last day of employment. You have 90 days from your last date of employment (but in no event after 3/31/22) to submit claims documentation or your funds will be forfeited.**

Remember, you must enroll every year during Open Enrollment.

Limited Medical FSA for HDHP participants

If you are enrolled in the High Deductible Health Plan with a Health Savings Account (HSA), you are only eligible to enroll in a limited medical FSA. This limits the use of your FSA funds to dental and vision expenses only, so please make your elections accordingly.

Transportation Expense Reimbursement Account (All Employees)

A Transportation Expense Reimbursement Account (TERA) can be used to reimburse expenses related to traveling to and from work and for parking while at work. You shouldn't enroll in TERA if you already have a payroll deduction for a parking lot or garage.

The 2021 contribution limit is \$265 per month, or \$3,180 annually, **for parking or transit expenses.** Unlike the other flex accounts, there are no carry-over limits for the TERA and members can enroll, cancel or change elections at any time during the plan year.

FLEXIBLE SPENDING ACCOUNTS Continued



Dependent Care FSA

A Dependent Care FSA allows you to set aside pre-tax dollars from your salary to pay for child care expenses so that you can go to work. The child care provider's Tax ID or Social Security number is required for reimbursement.

When you enroll, you choose the amount you wish to contribute for the coming year. The IRS limits the amount that you can contribute to your dependent care FSA on an annual basis. The maximum contribution limits for 2021 are shown in the chart below.

2021 ANNUAL DEPENDENT CARE CONTRIBUTION LIMITS	
SINGLE OR MARRIED, FILING JOINT TAX RETURNS	\$5,000
MARRIED, FILING SEPARATE TAX RETURNS	\$2,500

Contributions made in 2021 can only be used for dependent care expenses incurred January 1, 2021 – March 15, 2022. You can access funds by submitting a claim form to Custom Design Benefits for reimbursement. Claims must be submitted by March 31, 2022 to get reimbursed. **If claims are not submitted by the deadline, you will forfeit any money remaining in your FSA account. If you leave the City, you are only reimbursed for expenses incurred prior to your last day of employment.**

You have 90 days from your last date of employment (but in no event after 3/31/22) to submit claims for expenses or your funds will be forfeited.

Remember, you must enroll every year during Open Enrollment.

Eligible Dependent Care Expenses

Some of the dependent care expenses you can claim include:

- Licensed nursery school and day care centers for children under the age of 13;
- Licensed day care centers for disabled dependents either inside or outside your home. If outside your home, generally the provider must meet all licensing requirements.

Ineligible Dependent Care Expenses

- Care not necessary for you (or your spouse) to work;
- Care provided by your children who are under the age of 19 or by anyone you claim as a dependent for federal income tax purposes;
- Transportation, education, clothing or entertainment;
- Babysitting for social events.

Medical, Dependent Care, and TERA FSA Reminder



ENROLLMENT

You enroll in the Medical and Dependent Care FSA **every year**. Elections do not carry forward year to year.



MONTHLY ADMIN FEE

A \$3.00 monthly administration fee will be applied to your FSA. If you are enrolled in more than one, the fee will only be applied once.



SEPARATION

If you leave City employment, you will have 90 days (but not after 3/31/22) to submit claims for expenses incurred **prior** to your separation date.

LIFE INSURANCE

AFSCME, CODE, BUILDING TRADES, ELECTED OFFICIALS, & NON-REPRESENTED

Voluntary Life Insurance

The City of Cincinnati offers supplemental, spousal, and dependent life insurance plans to AFSCME, Code, Building Trades, Elected Officials, and Non-Represented. Individuals can apply for amounts of coverage up to the plan maximums shown below. **Now is the time to enroll because there will be no medical underwriting for Life Insurance (up to guaranteed amounts) during your first 30 days of employment.**

EVIDENCE OF INSURABILITY

If you elect amounts above the guaranteed issue amount, you may be required to complete evidence of insurability (EOI) and go through medical underwriting to qualify for coverage.

PREMIUM

You pay for the entire cost of the voluntary life plan. Cost is based on age, the amount of coverage that you purchase, and tobacco use of the employee. See COCBenefits.com for rates.

WHAT YOU CAN APPLY FOR

BENEFIT	GUARANTEED AMOUNT	MAXIMUM AMOUNT
EMPLOYEE	\$200,000 or six times your salary (whichever is less)	Up to \$500,000 or six times the employee's annual salary; whichever is less
SPOUSE/EQUAL PARTNER	\$50,000	Up to the employee's election up to \$300,000
CHILD(REN) UP TO AGE 26	\$2,000, \$5,000, or \$10,000	\$2,000; \$5,000 or \$10,000

LONG-TERM DISABILITY

AFSCME, CODE, BUILDING TRADES, ELECTED OFFICIALS, & NON-REPRESENTED

Long-Term Disability (LTD)

The City offers LTD to AFSCME, Code, Building Trades, Elected Officials, and Non-Represented. Long-term disability insurance is income replacement if you are unable to work for an extended period of time due to illness or injury. **Now is the time to enroll because there will be no medical underwriting during your first 30 days of employment.**

HOW IT WORKS

The long-term disability plan pays 60% of your monthly income **tax free** up to the plan maximum of \$10,000 per month. The plan has a 90-day elimination period. This means that the benefits will begin to pay on the 91st day of your disability. Claims are not guaranteed. All claims must be approved by Voya. Premiums are determined by your age and salary. See COCBenefits.com for rates.



A \$2.00 monthly administration fee applies to the life and long term disability plan. If you are enrolled in both plans, you will only be subject to one monthly fee. If you are enrolled in a Flexible Spending Account, you will not be charged the monthly fee for the life or disability.

CRITICAL ILLNESS INSURANCE



Critical Illness insurance can help with the treatment costs of covered critical illnesses, such as cancer, a heart attack or a stroke. With the Critical Illness plan, you receive cash benefits directly, giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

- **Cash benefits** are paid directly to you.
- **Children (up to age 26) are free** when employees elect coverage.
- **Pre-Existing Conditions:** Any condition treated in the 12 months prior to the effective date will not be eligible for coverage within the first 12 months of the policy.
- **Second Event Coverage:** Pays when you are diagnosed for the second time with a previously paid critical illness.
- **Wellness Benefit:** You can earn up to \$100 for yourself and \$100 for your spouse/equal partner and \$100 for each child (up to \$400 for family) for completing basic annual preventative tests.
- **Enrollment Age Premium Freeze:** Rates do not change as you age. Whatever age you are when you first enroll, you will remain in that premium band for the duration of your coverage.
- **Coverage is portable**, which means you can take it with you if you change jobs or retire.

CRITICAL ILLNESS BENEFIT LEVELS	
EMPLOYEE	\$10,000
SPOUSE	\$5,000
CHILD	\$5,000

CRITICAL ILLNESS SEMI-MONTHLY RATES (PER PAY, FOR 24 PAYS)		
ISSUE AGE	EE+CH	FAMILY
UNDER 30	\$2.66	\$4.24
30-39	\$3.76	\$5.81
40-49	\$7.31	\$10.69
50-59	\$13.96	\$19.79
60-64	\$20.46	\$29.21
65-69	\$26.71	\$38.41
70+	\$38.96	\$53.41

CRITICAL ILLNESS CASH PAYMENT EXAMPLES

1. Employee suffers a heart attack and is hospitalized.
2. Three years later the employee is diagnosed with cancer.
3. Four months later the employee has another heart attack and undergoes coronary artery bypass surgery.

HEART ATTACK	\$10,000
CANCER	\$10,000
SECOND HEART ATTACK	\$10,000
BYPASS SURGERY	\$2,500
TOTAL BENEFITS	\$32,500

WHAT DISEASES ARE COVERED?

CRITICAL ILLNESS INSURANCE

A "Critical Illness" is one of the following: Heart Attack, Stroke, Coronary Artery Bypass Graft, Cancer, End Stage Renal Disease, Major Organ Transplant, Benign Brain Tumor, Bone Marrow Transplant, Stem Cell Transplant, Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's Disease, and Advanced Dementia or Alzheimer's Disease.



ACCIDENT INSURANCE



Accident Insurance is designed to complement your existing medical coverage and help narrow gaps caused by out-of-pocket expenses such as deductibles, co-payments, and non-covered medical services.

Despite having medical coverage, many people are not adequately prepared for the out-of-pocket expenses that result from an accident. With Accident Insurance you will get:

- **Cash benefits** paid directly to you for accidents and injuries that happen off the job.
- **Coverage for the entire family**, including spouses, equal partners, and dependents up to age 26.
- **Wellness Benefit:** You can earn \$100 for yourself, \$100 for your spouse/equal partner, and \$100 per child (max \$200 for all children) by submitting non-accident physician visits, such as preventive screenings or dental & vision exams.



HOW TO FILE A CLAIM

Follow these basic steps for filing a claim with Voya:

1. Go to <https://claimcenter.voya.com>
2. To file an accident or illness claim, click on “start a claim”.
3. No login is required for accident/critical illness claims.
4. The City’s Group Number is 70710-4, BUT this is not required.

Check your email for your CLAIM number (not confirmation number). This will be the only way to check the status of your claim (you cannot “login” to the site for accident or critical illness claim status).

You can choose to have your money direct-deposited into your account or have a check sent to your attention.

ACCIDENT SEMI-MONTHLY RATES (PER PAY, FOR 24 PAYS)

EMPLOYEE	\$3.26
FAMILY	\$10.31

ACCIDENT CASH PAYMENT EXAMPLES

Car accident and individual is taken to the hospital. Cash payments as follows:

AMBULANCE SERVICE	\$240
HOSPITALIZATION	\$1,000
PHYSICAL THERAPY (6)	\$180
FOLLOW-UP VISITS (2)	\$120
TOTAL PAYMENTS	\$1,540

FILING A WELLNESS CLAIM?

To file a Wellness Claim, click the heart at the bottom of the page.



For wellness claims you will need:

- Name, dob, social of employee and claimant (if not employee)
- Doctor’s name, phone, and address
- Date of service
- Type of test conducted (annual physical, biometric screening, colonoscopy, mammogram, cancer screening, EKG, A1C, cholesterol test, routine dental exam, routine vision exam, plus others...)

ACCIDENT INSURANCE Continued



Benefit Amounts

BASE POLICY BENEFITS		PLAN 1
INITIAL HOSPITAL CONFINEMENT (pays once per accident)		\$1,000
DAILY HOSPITAL CONFINEMENT (pays daily)		\$300
INTENSIVE CARE (pays daily)		\$475
RIDER BENEFITS		PLAN 1
URGENT CARE		\$150
AMBULANCE	Ground	\$240
	Air	\$1000
ACCIDENT PHYSICIAN'S TREATMENT		\$60
X-RAY		\$30
DISLOCATION OR FRACTURE RIDER		Up to \$5,100
COMMON CARRIER ACCIDENTAL DEATH (Fare-paying passenger)		\$100,000/ \$50,000/ \$25,000
BENEFITS ENHANCEMENT RIDER		PLAN 1
ACCIDENT FOLLOW-UP TREATMENT (Pays daily)		\$60
LACERATIONS		Up to \$320
BURNS	2nd degree >35%	\$1,000
	3rd deg. 9-34%	\$4,500
	3rd degree >34%	\$10,000
SKIN GRAFT (% of Burns Benefit)		25%

BENEFITS ENHANCEMENT RIDER CONTINUED		PLAN 1
COMA WITH RESPIRATORY ASSISTANCE (14 or more days)		\$11,500
OPEN ABDOMINAL OR THORACIC SURGERY		\$800
TENDON, LIGAMENT, ROTATOR CUFF OR KNEE CARTILAGE SURGERY	Surgery	From \$500
	Exploratory	From \$150
RUPTURED SPINAL DISC SURGERY		\$500
EYE SURGERY		\$225
BLOOD AND PLASMA		\$400
APPLIANCE		\$40
PROSTHESIS	1 device	\$500
	2 or more devices	\$800
PHYSICAL, OCCUPATIONAL OR SPEECH THERAPY (Pays daily)		\$30 (max 6 per)
REHABILITATION UNIT		\$125/day (up to 90 days)
NON-LOCAL TRANSPORTATION		\$500/trip up to 3 per accident
FAMILY MEMBER LODGING		\$120
POST ACCIDENT TRANSPORTATION (Pays once/year)		\$500
BROKEN TOOTH		\$250 Emergency Dental Work (crown)
RESIDENCE/VEHICLE MODIFICATION		\$5,000
MISCELLANEOUS OUTPATIENT SURGERY		\$150

HEALTHY LIFESTYLES



Healthy Lifestyles is a voluntary wellness program that encourages and rewards employees and their spouses/equal partners for making positive choices for better health. Each participant can earn up to \$300/year by meeting certain health measures and completing programs in health education, weight management, preventive care, physical activity and other lifestyle programs. Incentives earned throughout the year will be deposited into your Custom Design Benefits Health Reimbursement Account after February 1st of the following year.

TriHealth Healthy Lifestyles staff works with an Employee Wellness Committee to provide a variety of on-site health screenings, educational classes and other programs for which you can earn credits. These events are marketed through monthly Healthy Lifestyles Newsletter, fliers, e-mails and word of mouth. For more information, or to log in to Healthy Lifestyles, go to: <https://www.trihealthcorporatewellness.com> (See login information on the next page).

Eligibility and Enrollment

City employees and their spouses/equal partners who are enrolled in the City's Anthem 80/20 plan or HDHP are eligible to participate in the Healthy Lifestyles Program. Employees who are enrolled in the City's integrated HRA plan with J&K are eligible for reimbursements from Healthy Lifestyles, but their spouses/equal partners are not.

Earning Cash Incentives

To earn the incentives for participation in Healthy Lifestyles, employees must be enrolled in a city health plan. If you are enrolled through another City employee, you still qualify to earn incentives, however, the money will only accumulate within the account of the employee who is paying the insurance premiums.

Incentives earned towards Healthy Lifestyles in 2021 will be deposited into your account in February 2022. **2021 funds will only be deposited into your account in 2022 if you and your spouse/equal partner are enrolled in a City health plan on January 1st, 2022.**

AMY DRISCOLL

Healthy Lifestyles Specialist

513.977.0018

Amy_Driscoll@TriHealth.com

The Healthy Lifestyles Program is coordinated through TriHealth Corporate Health. All Protected Health Information (PHI) will be kept confidential by TriHealth staff. The City of Cincinnati will not have access to PHI and will only review program information in aggregate form.



Please note that anyone enrolled in the HDHP plan will have their Healthy Lifestyles money deposited into their HSA, rather than their Healthy Lifestyles Account through Custom Design Benefits.



Don't forget to download and log into the new Health Lifestyles app! It's called "Health Path." Login to the Health Lifestyles portal to register your phone # with Access Code 1793 and then login to the app.



HEALTHY LIFESTYLES Continued



Diabetes & Hypertension Coaching



The City of Cincinnati and TriHealth partner with Kroger to assist those diagnosed with diabetes and/or hypertension to better manage their conditions.

The program is available to employees and their dependents, age 18 or older, who are enrolled in either the City's Anthem 80/20 health plan or the HDHP. Participants in the program receive:

- Individual counseling sessions from a specially trained Kroger Pharmacist
- Waiver of your drug copays for medications related to diabetes, hypertension and cholesterol

To enroll in the Kroger Diabetes & Hypertension Coaching Program, call 1.888.242.5841.

Healthy Lifestyles Wellness Portal

<https://www.trihealthcorporatewellness.com>

If you haven't already registered for the portal, you MUST do so to gain access. To access the wellness portal, you must go to the "Wellness Portal Sign In" page and enter your email and password. To verify your account you must enter the following username:

EMPLOYEE USER NAME

COC+employee id+1
Ex. "COC456781"

SPOUSE/EQUAL PARTNER USER NAME

COC+employee id+2
Ex. "COC456782"

Your password must be a minimum of 8 characters and must contain 1 capital letter and 1 number.

For assistance with your password or logging in, please call the Cerner Customer Care number at 888-252-8150.



TAKE ADVANTAGE of EMPLOYEE HEALTH SERVICES AND PEAP!

Located on the 1st floor of Centennial 2



- **FREE Urgent Care** visits for Full Time City employees! Call 352.1990 to schedule.
- **FREE Flu Shots** for full time City employees (and dependents age 4+ on City insurance).
- **FREE Biometric Screenings** for Healthy Lifestyles for Full Time employees and their Spouse/EP.
- **FREE Parking** for patients in marked spaces on West 9th Street, across from Gateway Apartments.
- **FREE Work Injury** treatment, including sutures, tetanus shots, specialist referrals, and prescriptions.
- **ON SITE PEAP APPOINTMENTS** located at Centennial 2. Call PEAP at 421-7600 to schedule.

PEAP is Here for you and your Family

Don't forget that PEAP offers **FREE** counseling to employees and their families for depression, stress issues, marital/family issues, chemical/alcohol dependency, work issues, and more.



Call 421-7600 to schedule your appointment.

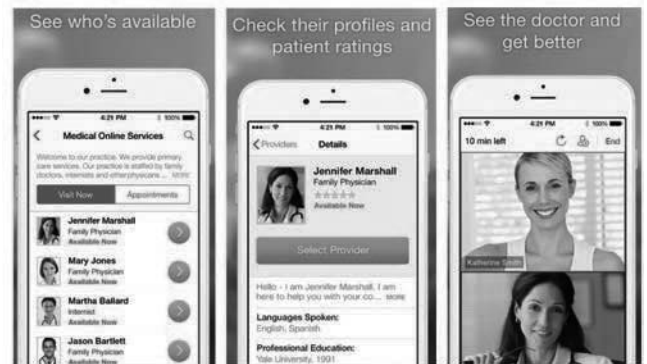
- **ON SITE PHYSICAL THERAPY** with TriHealth Physical Therapist for work or non-work related injuries. Call 346.1540 to schedule.

LIVE HEALTH ONLINE



LiveHealth Online for Medical and Mental Health Visits

Doctor visits and prescriptions 24/7 from the comfort of your own home! LiveHealth Online allows you to video chat with a board-certified physician who can answer questions, make a diagnosis and even **prescribe medications if needed**. LiveHealth Online also offers you access to a psychologist or therapist who can assist if you are experiencing symptoms related to




stress, anxiety or depression. LiveHealth Online costs **less than \$10 if you have already met your deductible!** If you cannot be treated online, you will not be charged.

Sign up for LiveHealth Online




by visiting livehealthonline.com or download the mobile app for Android or iPhone.



Use LiveHealth Online for minor (non-chronic) illnesses such as:

- Cold/flu symptoms
- Fever
- Allergies
- UTIs
- Cough
- Headaches
- Sinus infections

CONTACT INFORMATION

Just one stop for all your benefit needs. CINCINNATI 

COCBenefits.com

powered by 4MyBenefits

1-866-477-1604

www.COCBenefits.com

RISK MANAGEMENT

513.352.2418

DEBORAH ALLISON

513.352.3337

Risk Manager

Deborah.Allison@Cincinnati-OH.gov

SHEILA LAFFEY

513.352.6230

Benefits Manager

Sheila.Laffey@Cincinnati-OH.gov

PHYLISS WARD

513.352.2566

Administrative Specialist

Health, Dental and Vision Enrollments

Phyliss.Ward@Cincinnati-OH.gov

EHS

513.352.1990

PEAP

513.421.7600

TRI-HEALTH PHYSICAL THERAPY AT

EHS

513.346.1540

CONTACT INFORMATION Continued



www.AFSCMECarePlan.com

or 513.641.4111



Medical Group Number: W42582

www.anthem.com or 844.456.7112

Pharmacy

Group: WL5A

Bin: 020099

PCN: WG

Phone #: 844.456.7112

Member Services

- Call or log in to your Anthem account at www.anthem.com
- Have your member ID ready
- Provide location you would like to search
- Select FIND A DOCTOR
- Select a type of provider, place or name
- Enter your location
- SEARCH

Use the Mobile App

- Download the mobile app by searching "Sydney" in the App Store or Google Play store



www.CustomDesignBenefits.com or

513.598.2929



Group Number: 9731894

www.eyemed.com or 866.723.0514



www.FOP69.org

or 513.381.2550



CinciiHRA@catilizehealth.com or 877.872.4232



Group: S1029

www.SuperiorDental.com or 800.762.3159



www.trihealthcorporatewellness.com

AMY DRISCOLL *Healthy Lifestyles Specialist*

513.977.0018 / Amy_Driscoll@TriHealth.com



Customer Service:

Group Life and Disability: 800.955.7736

Critical Illness / Accident / Wellness: 877.236.7564

Claims:

Life 888.238.4840

Disability 888.305.0602

Critical Illness / Accident / Wellness 888.238.4840

www.voya.com

2021 INDEX OF REQUIRED NOTICES

- Summary of Benefits and Coverage **(80/20: AFSCME, CODE, NON-REP, BT, Police hired after 9/8/16, Fire hired after 4/27/16)**
- Summary of Benefits and Coverage **(80/20: Police hired before 9/8/16 and Fire hired before 4/27/16)**
- Summary of Benefits and Coverage **(High Deductible Plan with HSA)**
- Summary of Benefits and Coverage **(Integrated HRA)**
- Women’s Health and Cancer Rights & Special Enrollment
- Michelle’s Law Notice
- Children’s Health Insurance Program (CHIP) Notice
- COBRA Notice Letter
- Notice of City of Cincinnati’s Health Plan Privacy Practices (HIPAA)
- Medicare Part D Notice of Creditable Coverage
- EEOC Notice Regarding Wellness Programs
- Notice Regarding Wellness Program – Spouse/Dependent Authorization
- Glossary of Medical Terms

City of Cincinnati: AFSCME, CODE, Non-Represented, Building Trades, Police (hired after 9/8/2016), and Fire (hired after 4/27/16) - \$500 PPO

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, <https://eoc.anthem.com/eocdps/aso>. 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.healthcare.gov/sbc-glossary/ or call (844) 456-7112 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$500 /person or \$1,000 /family for In- <u>Network Providers</u> . \$1,000 /person or \$2,000 /family for Non- <u>Network Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive Care</u> for In- <u>Network Providers</u> . Tier 1 Tier 2 Tier 3 <u>Prescription Drugs</u> for In- <u>Network Providers</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$2,000 /person or \$4,000 /family for In- <u>Network Providers</u> . \$4,000 /person or \$8,000 /family for Non- <u>Network Providers</u> . This <u>plan</u> has a separate Out of Pocket Maximum of \$6,150 /person or \$12,300 /family for In- <u>Network Providers</u> for <u>Prescription Drugs</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if	Yes, Blue Access. See	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u>

you use a <u>network provider</u>?	www.anthem.com or call (844) 456-7112 for a list of <u>network providers</u> .	<u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	<u>Specialist</u> visit	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://www.anthem.com/pharmacyinformation/ Essential Drug List	Tier 1 - Typically Generic	\$10/prescription, <u>deductible</u> does not apply (retail) and \$20/prescription, <u>deductible</u> does not apply (home delivery)	Not covered (retail) and Not covered (home delivery)	*See Prescription Drug section
	Tier 2 - Typically <u>Preferred Brand</u> & <u>Non-Preferred Generic</u> Drugs	\$20/prescription, <u>deductible</u> does not apply (retail) and \$40/prescription, <u>deductible</u> does not apply (home delivery)	Not covered (retail) and Not covered (home delivery)	
	Tier 3 - Typically <u>Non-Preferred Brand</u> and Generic drugs	\$30/prescription, <u>deductible</u> does not apply (retail) and \$60/prescription, <u>deductible</u> does not apply (home delivery)	Not covered (retail) and Not covered (home delivery)	

* For more information about limitations and exceptions, see plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	Covered as In-Network	-----none-----
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Covered as In-Network	Non-emergency non-network Ambulance Services are limited to \$50,000 per occurrence.
	<u>Urgent care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	60 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 20% <u>coinsurance</u> Other Outpatient 20% <u>coinsurance</u>	Office Visit 50% <u>coinsurance</u> Other Outpatient 50% <u>coinsurance</u>	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	30 visits/benefit period for Home Health and Private Duty Nursing combined.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	*See Therapy Services section.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	90 visits/benefit period.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	*See <u>Durable Medical Equipment</u> Section
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
	Children's eye exam	20% <u>coinsurance</u>	50% <u>coinsurance</u>	*See Vision Services section.
	Children's glasses	Not covered	Not covered	

* For more information about limitations and exceptions, see **plan** or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's dental check-up	Not covered	Not covered	-----none-----

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"> • Acupuncture • Dental care (Pediatric) • Hearing aids • Routine foot care unless you have been diagnosed with diabetes 	<ul style="list-style-type: none"> • Cosmetic surgery • Dental Check-up • Infertility treatment • Weight loss programs 	<ul style="list-style-type: none"> • Dental care (Adult) • Glasses for a child • Long-term care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Bariatric Surgery • Private-duty nursing 30 visits/benefit period combined with Home Health 	<ul style="list-style-type: none"> • Chiropractic care 12 visits/benefit period • Routine eye care (Adult) 	<ul style="list-style-type: none"> • Most coverage provided outside the United States. See www.bcbsglobalcore.com

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, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, or contact Anthem at the number on the back of your ID card. 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:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

* For more information about limitations and exceptions, see plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

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 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.

—————*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 plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

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)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)
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■ The <u>plan's</u> overall <u>deductible</u>	\$500	■ The <u>plan's</u> overall <u>deductible</u>	\$500	■ The <u>plan's</u> overall <u>deductible</u>	\$500
■ <u>Specialist coinsurance</u>	20%	■ <u>Specialist coinsurance</u>	20%	■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	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*)

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*)

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	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,060

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,060

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$900

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

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (844) 456-7112

Amharic (አሁክላል): ስስስስ ስስስ ስስስስስ ስስስ ስስስስ ስስስስ ስስስ ስስስስ ስስስ ስስስስ ስስስ ስስስ ስስስ ስስስ ስስስስ ስስስስስ ስስስስስ ስስስስስ (844) 456-7112 ስስስስስ

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (844) 456-7112.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչ ի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (844) 456-7112:

Bassa (𞄂𞄃𞄄𞄅 Wùdù): M̄ dyi dyi-diè-dɛ bɛ bédé bá céè-dɛ nià kɛ dyí ní, ɔ mò ni dyí-bédèin-dɛ bɛ m̄ kɛ gbo-kpá-kpá kè bɔ̄ kpɔ̄ dɛ m̄ bídí-wùdùùn bó pídyi. Bɛ m̄ kɛ wuɖu-zìin-nyò dò gbo wùdù kɛ, dá (844) 456-7112.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (844) 456-7112 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (844) 456-7112 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(844) 456-7112。

Dinka (Dinka): Na nɔŋ thiëc nē ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wɛr alēu bē gɛɛr yic yin ne thoŋ du ke cin wēu tāäuē ke piny. Te kɔr yin ba jam wēnē ran ye thok geryic, ke yin cɔl (844) 456-7112.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (844) 456-7112.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (844) 456-7112 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 456-7112.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (844) 456-7112.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (844) 456-7112.

Gujarati (ગુજરાતી): જો આ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની વવાનો તમન દસ્તાવજ ભાષામાં મદદ અને માહિતી મળ

આ કાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (844) 456-7112.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (844) 456-7112.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (844) 456-7112 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (844) 456-7112.

Igbo (Igbo): O bụr u na i nwere ajuju o bula gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o bula. Ka gi na okowa okwu kwuo okwu, kpoo (844) 456-7112.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (844) 456-7112.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (844) 456-7112.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 456-7112

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利がありま

す。通訳と話すには、(844) 456-7112 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ (844) 456-7112 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (844) 456-7112.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (844) 456-7112 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັບກ່ຽວກັບພາສາ, ໃຫ້ໂທຫາ (844) 456-7112.

Navajo (Diné): Díí naaltsoos biká'ígíí lahgo bina'idiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjı́ bee nił hodoonih t'áadoo bááh ilínígóó.
Ata' halne'ígíí la' bich'ı́' hadeesdzih nínizingo kojı́' hodiłnih (844) 456-7112.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (844) 456-7112

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (844) 456-7112 bilbilla.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (844) 456-7112 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz praw o do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (844) 456-7112.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (844) 456-7112.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (844) 456-7112 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (844) 456-7112.

Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (844) 456-7112.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i leni tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (844) 456-7112.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (844) 456-7112.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (844) 456-7112.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (844) 456-7112.

Thai (ไทย): หากท่านมีคำถามเกี่ยวกับเอกสารฉบับนี้ จะได้รับ ความช่วยเหลือ และขอ ่าเข้าใจ ่าย โดยโทร
หากท่านมี คำถามสับสน ลอ มุลในภาษาของท่านโดยไม่มค

(844) 456-7112 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (844) 456-7112.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (844) 456-7112 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (844) 456-7112.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (844) 456-7112.

Yoruba (Yorùbá): Tí o bá ní èyíkẹyí ibèrè nípa àkọsílẹ̀ yí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè ẹ̀rẹ̀ lẹ́fẹ́. Bá wa ògbùfọ̀ kan sọrọ̀, pe (844) 456-7112.

Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

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, <https://eoc.anthem.com/eocdps/aso>. 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.healthcare.gov/sbc-glossary/ or call (844) 456-7112 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$300 /person or \$600 /family for In- <u>Network Providers</u> . \$600 /person or \$1,200 /family for Non- <u>Network Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive Care</u> for In- <u>Network Providers</u> . Tier 1 Tier 2 Tier 3 <u>Prescription Drugs</u> for In- <u>Network Providers</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$1,500 /person or \$3,000 /family for In- <u>Network Providers</u> . \$3,000 /person or \$6,000 /family for Non- <u>Network Providers</u> . This <u>plan</u> has a separate Out of Pocket Maximum of \$6,650 /person or \$13,000 /family for In- <u>Network Providers</u> for <u>Prescription Drugs</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes, Blue Access. See www.anthem.com or call (844) 456-7112 for a list of <u>network</u>	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive

	<u>providers.</u>	a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		In-Network Provider (You will pay the least)	Non-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	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	<u>Specialist</u> visit	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://www.anthem.com/pharmacyinformation/ Essential Drug List	Tier 1 - Typically Generic	\$10/prescription, <u>deductible</u> does not apply (retail) and \$20/prescription, <u>deductible</u> does not apply (home delivery)	Not covered (retail) and Not covered (home delivery)	*See Prescription Drug section
	Tier 2 - Typically <u>Preferred Brand</u> & Non- <u>Preferred</u> Generic Drugs	\$20/prescription, <u>deductible</u> does not apply (retail) and \$40/prescription, <u>deductible</u> does not apply (home delivery)	Not covered (retail) and Not covered (home delivery)	
	Tier 3 - Typically Non- <u>Preferred</u> Brand and Generic drugs	\$30/prescription, <u>deductible</u> does not apply (retail) and \$60/prescription, <u>deductible</u> does not apply (home delivery)	Not covered (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----

* For more information about limitations and exceptions, see plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	Covered as In-Network	-----none-----
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Covered as In-Network	Non-emergency non-network Ambulance Services are limited to \$50,000 per occurrence.
	<u>Urgent care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	60 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 20% <u>coinsurance</u>	Office Visit 50% <u>coinsurance</u>	Office Visit -----none-----
		Other Outpatient 20% <u>coinsurance</u>	Other Outpatient 50% <u>coinsurance</u>	Other Outpatient -----none-----
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	30 visits/benefit period for Home Health and Private Duty Nursing combined.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	*See Therapy Services section.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	90 days/benefit period for skilled nursing services combined.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	*See <u>Durable Medical Equipment</u> Section
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
If your child needs dental or eye care	Children's eye exam	20% <u>coinsurance</u>	50% <u>coinsurance</u>	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	-----none-----

* For more information about limitations and exceptions, see **plan** or policy document at <https://eoc.anthem.com/eocdps/aso>.

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
- Dental care (Pediatric)
- Hearing aids
- Routine foot care unless you have been diagnosed with diabetes
- Cosmetic surgery
- Dental Check-up
- Infertility treatment
- Weight loss programs
- Dental care (Adult)
- Glasses for a child
- Long-term care

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

- Bariatric Surgery
- Private-duty nursing 30 visits/benefit period combined with Home Health
- Chiropractic care 12 visits/benefit period
- Routine eye care (Adult)
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

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, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, or contact Anthem at the number on the back of your ID card. 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:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

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.

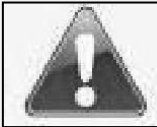
Does this plan meet the Minimum Value Standards? **Yes**

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.

—————*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 plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <u>plan's</u> overall <u>deductible</u>	\$300	■ The <u>plan's</u> overall <u>deductible</u>	\$300	■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist coinsurance</u>	20%	■ <u>Specialist coinsurance</u>	20%	■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%	■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%	■ Other <u>coinsurance</u>	20%
<p>This EXAMPLE event includes services like:</p> <p><u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<u>Cost Sharing</u>		<u>Cost Sharing</u>		<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300	<u>Deductibles</u>	\$300	<u>Deductibles</u>	\$300
<u>Copayments</u>	\$0	<u>Copayments</u>	\$1,000	<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,200	<u>Coinsurance</u>	\$200	<u>Coinsurance</u>	\$400
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0
The total Peg would pay is	\$1,560	The total Joe would pay is	\$1,560	The total Mia would pay is	\$700

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

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (844) 456-7112

Amharic (አሁኛ): ስስስስ ስስስ ስስስስስ ስስስ ስስስስ ስስስስ ስስስ ስስስስ ስስ ስስስ ስስስ ስስስ ስስስስስ ስስስስስ ስስስስስ (844) 456-7112 ስስስስስ

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (844) 456-7112.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (844) 456-7112:

Bassa (Bàsɔ̀ wùdù): M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédédé b́á cèè-dɛ̀ nìà kɛ dyí ní, ɔ̀ m̀ò nì dyí-bɛ̀dɛ̀n-dɛ̀ b́é m̀ kɛ gbo-kpá-kpá kè b̄́ kp̄́ d́é m̀ b́í d́í-wùdùùn b́ó ṕídyi. B́é m̀ kɛ wuɖu-zìin-nyò d̀ò gbo wùdù kɛ, d́á (844) 456-7112.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (844) 456-7112 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (844) 456-7112 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(844) 456-7112。

Dinka (Dinka): Na nɔŋ thiëc nē ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wɛr alēu bē gɛɛr yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te kɔr yin ba jam wēnē ran ye thok geryic, ke yin cɔl (844) 456-7112.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (844) 456-7112.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (844) 456-7112 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 456-7112.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (844) 456-7112.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (844) 456-7112.

Gujarati (ગજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (844) 456-7112.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (844) 456-7112.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (844) 456-7112 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (844) 456-7112.

Igbo (Igbo): O bụrụ na ị nwere ajuju o bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ o bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (844) 456-7112.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (844) 456-7112.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (844) 456-7112.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 456-7112

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利がありま

Language Access Services:

す。通訳と話すには、(844) 456-7112 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ (844) 456-7112 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (844) 456-7112.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(844) 456-7112 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັບວ່າມີພາສາ, ໃຫ້ໃບທາ (844) 456-7112.

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idílkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bąąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninízingo kojí' hodiilnih (844) 456-7112.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (844) 456-7112

Oromo (Oromifaa): Sanadi kanaa wajjin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (844) 456-7112 bilbilla.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (844) 456-7112 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (844) 456-7112.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (844) 456-7112.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (844) 456-7112 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (844) 456-7112.

Russian (Русский): Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (844) 456-7112.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totoi. Ina ia talanoa i se tagata faaliliu, vili (844) 456-7112.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (844) 456-7112.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (844) 456-7112.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (844) 456-7112.

Thai (ไทย): หากท่านมีคำถามใดๆ นมสททจะไ้ร้ ยเหลอและขอมลในภาษาของท่านโดยไมม่คาคไข้ ย โดยโทร
เกี่ยวกับเอกสารฉบับนี้้ ทา ้บความชว ๗

(844) 456-7112 เพอพดคยกับลาม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (844) 456-7112.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (844) 456-7112 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (844) 456-7112.


(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (844) 456-7112.

Yoruba (Yorùbá): Tí o bá ní èyíkẹyí ibèrè nípa àkọsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ̀ lọfẹ́fẹ́. Bá wa ògbùfọ̀ kan sọrọ̀, pe (844) 456-7112.


Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

 **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 Catilize Health at 877-872-4232. 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.com or call 1-877-872-4232 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$ 0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Not Applicable	
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Not Applicable	This plan does not have an <u>out-of-pocket</u> limit on your expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Not Applicable	This plan does not have an <u>out-of-pocket</u> limit on your expenses.
Will you pay less if you use a <u>network provider</u> ?	Yes	Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Indirectly only	This plan will not reimburse for expenses not covered by the alternate coverage, And the alternate coverage may require a referral to see the specialist.

 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	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
	<u>Specialist</u> visit	\$0	\$0	
	<u>Preventive care/screening/immunization</u>	\$0	\$0	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
	Imaging (CT/PET scans, MRIs)	\$0	\$0	
If you need drugs to treat your illness or condition	Generic drugs	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any drug not covered by the alternate coverage will not be reimbursed under this plan.
	Preferred brand drugs	\$0	\$0	
	Non-preferred brand drugs	\$0	\$0	
	<u>Specialty drugs</u>	\$0	\$0	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
	Physician/surgeon fees	\$0	\$0	

* 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
	<u>Emergency medical transportation</u>	\$0	\$0	
	<u>Urgent care</u>	\$0	\$0	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
	Physician/surgeon fees	\$0	\$0	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
	Inpatient services	\$0	\$0	
If you are pregnant	Office visits	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
	Childbirth/delivery professional services	\$0	\$0	
	Childbirth/delivery facility services	\$0	\$0	

* 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$0	\$0	You may have coverage for this service under the alternative coverage, but not under this plan. This plan reimburses for co-pays, co-insurance and deductibles incurred under the alternate coverage up to the annual limit, if any. Any procedure not covered by the alternate coverage will not be reimbursed under this plan.
	<u>Rehabilitation services</u>	\$0	\$0	
	<u>Habilitation services</u>	\$0	\$0	
	<u>Skilled nursing care</u>	\$0	\$0	
	<u>Durable medical equipment</u>	\$0	\$0	
	<u>Hospice services</u>	\$0	\$0	
If your child needs dental or eye care	Children's eye exam	Not Covered		Not Covered
	Children's glasses			
	Children's dental check-up			

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.)

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Any expense payable through another source (such as the alternate coverage) • Bariatric surgery • Chiropractic care • Cosmetic Surgery | <ul style="list-style-type: none"> • Dental care (Adult) • Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (adult) • 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.)

- | | | |
|---|---|---|
| • | • | • |
|---|---|---|

* 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: 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 plan at 1-877-872-4232. You may also 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? [No]

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? [N/A] – integrated with standard plan

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.

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 \$N/A
- Specialist [co-pay/co-insurance] \$N/A
- Hospital (facility) [co-pay/co-insurance] %N/A
- Other [co-pay/co-insurance] %N/A

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$ N/A
Copayments	\$ N/A
Coinsurance	\$ N/A
<i>What isn't covered</i>	
Limits or exclusions	\$ N/A
The total Peg would pay is	\$ N/A

This plan does not cover specific services, it only pays for co-pays, co-insurance and deductibles up to the amount available in the HRA

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible \$N/A
- Specialist [co-pay/co-insurance] \$N/A
- Hospital (facility) [co-pay/co-insurance] %N/A
- Other [co-pay/co-insurance] %N/A

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$ N/A
Copayments	\$ N/A
Coinsurance	\$ N/A
<i>What isn't covered</i>	
Limits or exclusions	\$ N/A
The total Joe would pay is	\$ N/A

This plan does not cover specific services, it only pays for co-pays, co-insurance and deductibles up to the amount available in the HRA

Mia's Simple Fracture

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

- The plan's overall deductible \$N/A
- Specialist [co-pay/co-insurance] \$N/A
- Hospital (facility)[co-pay/co-insurance] %N/A
- Other [co-pay/co-insurance] %N/A

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$ N/A
Copayments	\$ N/A
Coinsurance	\$ N/A
<i>What isn't covered</i>	
Limits or exclusions	\$ N/A
The total Mia would pay is	\$ N/A

This plan does not cover specific services, it only pays for co-pays, co-insurance and deductibles up to the amount available in the HRA



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, <https://eoc.anthem.com/eocdps/aso>. 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.healthcare.gov/sbc-glossary/ or call (844) 456-7112 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,800 /person or \$5,600 /family for In- <u>Network Providers</u> . \$5,600 /person or \$11,200 /family for Non- <u>Network Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive Care</u> for In- <u>Network Providers</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$3,400 /person or \$6,800 /family for In- <u>Network Providers</u> . \$6,800 /person or \$13,600 /family for Non- <u>Network Providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, and Non- <u>Network Transplants</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes, <u>Blue Access</u> . See www.anthem.com or call (844) 456-7112 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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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
		In-Network Provider (You will pay the least)	Non-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	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	<u>Specialist</u> visit	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Preventive care/screening/immunization	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://www.anthem.com/pharmacyinformation/ Essential Drug List	Tier 1 - Typically Generic	20% <u>coinsurance</u> (retail and home delivery)	Not covered (retail) and Not covered (home delivery)	*See Prescription Drug section
	Tier 2 - Typically <u>Preferred Brand</u> & Non- <u>Preferred Generic</u> Drugs	20% <u>coinsurance</u> (retail and home delivery)	Not covered (retail) and Not covered (home delivery)	
	Tier 3 - Typically Non- <u>Preferred Brand</u> and Generic drugs	20% <u>coinsurance</u> (retail and home delivery)	Not covered (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	Covered as In- <u>Network</u>	-----none-----
	Emergency medical transportation	20% <u>coinsurance</u>	Covered as In- <u>Network</u>	Non-emergency non- <u>network</u> Ambulance Services are limited to \$50,000 per occurrence.
	<u>Urgent care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----

* For more information about limitations and exceptions, see plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	60 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 20% <u>coinsurance</u> Other Outpatient 20% <u>coinsurance</u>	Office Visit 50% <u>coinsurance</u> Other Outpatient 50% <u>coinsurance</u>	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	30 visits/benefit period for Home Health and Private Duty Nursing combined.
	Rehabilitation services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	*See Therapy Services section.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Skilled nursing care	20% <u>coinsurance</u>	50% <u>coinsurance</u>	90 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	*See <u>Durable Medical Equipment Section</u>
	Hospice services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----none-----
If your child needs dental or eye care	Children's eye exam	20% <u>coinsurance</u>	50% <u>coinsurance</u>	*See Vision Services section.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	-----none-----

* For more information about limitations and exceptions, see **plan** or policy document at <https://eoc.anthem.com/eocdps/aso>.

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
- Dental care (Pediatric)
- Hearing aids
- Routine foot care unless you have been diagnosed with diabetes
- Cosmetic surgery
- Dental Check-up
- Infertility treatment
- Weight loss programs
- Dental care (Adult)
- Glasses for a child
- Long-term care

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

- Bariatric Surgery
- Private-duty nursing 30 visits/benefit period combined with Home Health
- Chiropractic care 12 visits/benefit period
- Routine eye care (Adult)
- Most coverage provided outside the United States. See www.bcbglobalcore.com

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, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, or contact Anthem at the number on the back of your ID card. 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:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

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 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.

—————*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 plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ <u>The plan's overall deductible</u>	\$2,800	■ <u>The plan's overall deductible</u>	\$2,800	■ <u>The plan's overall deductible</u>	\$2,800
■ <u>Specialist coinsurance</u>	20%	■ <u>Specialist coinsurance</u>	20%	■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%	■ <u>Hospital (facility) coinsurance</u>	20%	■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	20%	■ <u>Other coinsurance</u>	20%	■ <u>Other coinsurance</u>	20%
<p>This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<u>Cost Sharing</u>		<u>Cost Sharing</u>		<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,800	<u>Deductibles</u>	\$2,800	<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0	<u>Copayments</u>	\$0	<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,200	<u>Coinsurance</u>	\$1,200	<u>Coinsurance</u>	\$400
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0
The total Peg would pay is	\$4,060	The total Joe would pay is	\$4,060	The total Mia would pay is	\$1,900

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

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 456-7112.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (844) 456-7112.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (844) 456-7112.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્ન હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને

અધિકાર છે. દુભાષણ સાથે વાત કરવા માટે, કોલ કરો (844) 456-7112.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprete, rele (844) 456-7112.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (844) 456-7112 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (844) 456-7112.

Igbo (Igbo): O bur u na i nwere ajuju o bu la gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o bu la. Ka gi na okowa okwu kwuo okwu, kpoo (844) 456-7112.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (844) 456-7112.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (844) 456-7112.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 456-7112

Language Access Services:

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(844) 456-7112 にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ (844) 456-7112 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (844) 456-7112.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(844) 456-7112 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໄວ້ວິມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (844) 456-7112.

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idíilkidgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'i' hadeesdzih nínízingo kojí' hodíilnih (844) 456-7112.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (844) 456-7112

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (844) 456-7112 bilbilla.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (844) 456-7112 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (844) 456-7112.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (844) 456-7112.

Language Access Services:

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (844) 456-7112.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (844) 456-7112.

Yoruba (Yorùbá): Tí o bá ní èyíkéyí ibèrè nípa àkòsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ̀ lọ́fẹ́ẹ̀. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (844) 456-7112.
It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Language Access Services:

Women's Health and Cancer Rights Act of 1998 (W HCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For an individual receiving mastectomy-related benefits, coverage will be provided in a manner determined by consultation with the attending physician and patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema in a manner determined in consultation with the attending physician and the patient

Special Enrollment

If you are declining enrollment for you or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll you or your dependents in the plan, provided that your request enrollment within 30 days after your other coverage ends (COBRA or state continuation coverage ends, divorce, legal separation, death, termination of employment or reduction in hours worked; or because the employer contributions cease).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll you and your dependents, provided you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you decline enrollment for yourself or for your dependents (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

If you have any questions, please contact Risk Management at 513-352-2418.

Michelle's Law

Michelle's Law prohibits the termination of health coverage if the child takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must:

- Be medically necessary (and certified by a physician as medically necessary)
- Commence while the child is suffering from a serious illness or injury
- Cause the child to lose student status for the purposes of coverage under the plan (either from an absence from school or reducing his/her course load to part time)

To take advantage of the extension, the child must be enrolled in the group health plan by being a student at a post-secondary educational institution immediately before the first day of the leave. Coverage must extend for one year after the first day of the leave (or, if earlier, the date coverage would otherwise terminate under the plan). The student on leave is entitled to the same benefits as if they had not taken a leave. If coverage changes during the student's leave, then this law applies in the same manner as the prior coverage.

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx <small>x</small>	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

<p align="center">CALIFORNIA – Medicaid</p> <p>Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676</p>	<p align="center">INDIANA – Medicaid</p> <p>Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584</p>
<p align="center">IOWA – Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563</p>	<p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084</p>
<p align="center">KANSAS – Medicaid</p> <p>Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p align="center">KENTUCKY – Medicaid</p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov</p> <p>KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: https://chfs.ky.gov</p>	<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcftp.nv.gov Medicaid Phone: 1-800-992-0900</p>
<p align="center">LOUISIANA – Medicaid</p> <p>Website: www.medicare.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218</p>
<p align="center">MAINE – Medicaid</p> <p>Enrollment Website: https://www.maine.gov/dhhs/ofa/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofa/applications-forms Phone: -800-977-6740. TTY: Maine relay 711</p>	<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739</p>	<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	VERMONT – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItE Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number.

The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebbsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

October 1, 2020

Re: Continuation Coverage Rights Under COBRA

Dear Employee:

You're getting this notice because you either recently gained coverage under the City's group health plan (the Plan) or you are maintaining your coverage during Open Enrollment. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child losing eligibility for coverage as a dependent child), the employee or a family member has a legal obligation to notify the City of Cincinnati or the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Chard, Snyder & Associates, Inc. 1-833-212-1988 or COBRA@Chard-Snyder.com.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. To benefit from this extension, a qualified beneficiary must notify the Plan Administrator of that determination within 60 days and before the end of the original 18-month period. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

If you have any questions about COBRA, please contact Phylliss Ward at (513)352-2566. Also, if you have a change in family status (marriage, divorce, birth, death etc.) please log in to CoCBenefits.com to enter the Qualifying Life Event within 31 days of the change.

Very truly yours,

Deborah Allison
Risk Manager

NOTICE

CITY OF CINCINNATI

HEALTH PLAN PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USE AND DISCLOSURE OF HEALTH INFORMATION

The Health Plan may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), for purposes of making or obtaining payment for your care and conducting health care operations. The Health Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment. The Health Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. The Health Plan may use or disclose health information for its own operations to facilitate the administration of the Health Plan and as necessary to provide coverage and services to all of the Health Plan’s participants. Health Care Operations include such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence of qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Health Plan, including customer service and resolution of complaints.

For Treatment Alternatives. The Health Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services. The Health Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Sponsor. The Health Plan may disclose your health information to the plan sponsor for plan administration functions performed by the plan sponsor on behalf of the Health Plan. In addition, the Health Plan may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate the plan. The Health Plan may also disclose to the plan sponsor information on whether you are participating in the health plan.

When Legally Required. The Health Plan will disclose your health information when it is required to do so by any federal, state, or local law.

To Conduct Health Oversight Activities. The Health Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Health Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings. As permitted or required by state law, the Health Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Health Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purpose. As permitted or required by state law, the Health Plan may disclose your health information to a law enforcement official for certain law enforcement purpose, including, but not limited to, if the Health Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety. The Health Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Health Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, federal regulations require the Health Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Workers' Compensation. The Health Plan may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Health Plan will not disclose your health information other than with your written authorization. If you authorize the health plan to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You may have the following rights regarding your health information that the Health Plan maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Health Plan's disclosure of your health information to someone involved in the payment of your care. However, the Health Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the Division of Risk Management at (513) 352-2418.

Right to Receive Confidential Communications. You have the right to request that the Health Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Health Plan only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to: Division of Risk Management, 805 Central Avenue, Centennial Plaza Two - Suite 100, Cincinnati, OH. 45202 fax (513) 352-3761. The Health Plan will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to: Division of Risk Management, 805 Central Avenue, Centennial Plaza Two – Suite 100, Cincinnati, OH. 45202 fax (513) 352-3761. If you request a copy of your health information, the Health Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Health Plan amend the records. That request may be made as long as the information is maintained by the Health Plan. A request for an amendment of records must be made in writing to: the Division of Risk Management, 805 Central Avenue, Centennial Plaza Two – Suite 100, Cincinnati, OH. 45202 fax (513) 352-3761. The Health Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Health Plan, if the health information you are requesting to amend is not part of the Health Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Health Plan determines the records containing your health information are accurate and complete.

Right to an Accounting. You have the right to request a list of certain disclosures of your health information that the Health Plan is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing to the Division of Risk Management, 805 Central Avenue, Centennial Plaza Two – Suite 100, Cincinnati, OH. 45202 fax (513) 352-3761. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Health Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Health Plan will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact Risk Management at (513) 352-2418. You may also obtain a copy of the current version of the Health Plan's Notice at the City's Web site at <http://citymatters.rcc.org/finance/riskmgmt/>.

DUTIES OF THE HEALTH PLAN

The Health Plan is required by law to maintain the privacy of your health plan information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Health Plan is required to abide by the terms of this notice, which may be amended from time to time. The Health Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Health Plan changes its policies and procedures, the Health Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Health Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Health Plan should be made in writing to: Ms. Deborah Allison, Privacy Official, Division of Risk Management, 805 Central Avenue, Centennial Plaza Two – Suite 100, Cincinnati, OH. 45202. The Health Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The Health Plan has designated the Privacy Official as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at: Ms. Deborah Allison, Privacy Official, Division of Risk Management, 805 Central Avenue, Centennial Plaza Two – Suite 100, Cincinnati, OH. 45202, phone number (513) 352-2418.

EFFECTIVE DATE

This Notice is effective April 14, 2003.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT THE PRIVACY OFFICIAL AT THE DIVISION OF RISK MANAGEMENT, 805 CENTRAL AVENUE, CENTENNIAL PLAZA TWO – SUITE 100, CINCINNATI, OH. 45202 PHONE (513) 352-2418.

Important Notice from the City of Cincinnati About Your Prescription Drug Coverage and Medicare

The City of Cincinnati is sending you this notice because you have a Medical policy that includes benefits for prescription drugs. Now that Medicare Part D is available, Medicare Eligible individuals have more choices in prescription drug coverage.

Please read this notice carefully and keep it where you can find it. This notice has information about current prescription drug coverage with the City of Cincinnati for people who are Medicare eligible or will become Medicare eligible in 2021. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

If you are not Medicare eligible, and none of your covered family members are Medicare eligible, no action is required on your part.

Medicare Eligible Members: Read this notice carefully - it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

It has been determined that the prescription drug coverage offered by the City of Cincinnati through OptumRx is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay, and is Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. If you drop your City of Cincinnati coverage and you choose to wait to join a Medicare drug plan, you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition, if you lose or decide to leave the City's sponsored coverage; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Stand-alone Medicare prescription drug plan. **If you decide to drop your City of Cincinnati Medical plan with prescription drug coverage, be aware that you may not be able to get this coverage back.**

You should also know that if you drop or lose your coverage with the City of Cincinnati and don't enroll in Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. For example, if you go

nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next October to enroll.

For more information about this notice or your current prescription drug coverage...

Contact our office for further information – Sheila Laffey (513)352-6230. NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You may also request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage will be available in the “Medicare & You” handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help,
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

**U.S. Equal Employment Opportunity Commission
NOTICE REGARDING WELLNESS PROGRAM**

The City of Cincinnati Healthy Lifestyles Program is a voluntary wellness program available to all full time employees who are either enrolled in a City medical plan with Anthem or in the City's integrated HRA plan with J&K. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary personal health assessment or "PHA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for Total Cholesterol, HDL, LDL, Triglycerides and Glucose. You are not required to complete the PHA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of up to \$300 for completing available incentives. Although you are not required to complete the PHA or participate in the biometric screening, only employees who do so will receive the PHA and biometric incentives (up to \$130).

Additional incentives of up to \$300 may be available for employees who participate in certain health-related activities such as preventive screenings, physical activity, etc. or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Amy Driscoll at (513)977-0018.

The information from your PHA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as wellness workshops and coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

The City is required by law to maintain the privacy and security of your personally identifiable health information. Although the City of Cincinnati wellness team may use aggregate information it collects to design a program based on identified health risks in the

workplace, Healthy Lifestyles will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are those who are part of the TriHealth Wellness Team and the Kroger Diabetes and Hypertension Coaching team, in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Risk Management at 352-2418.

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workplace, Healthy Lifestyles will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are those who are part of the TriHealth Wellness Team and the Kroger Diabetes and Hypertension Coaching team, in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Risk Management at 352-2418.

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

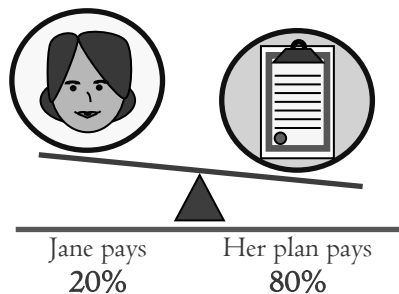
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance *plus* any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.)



Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% Her plan pays 0%

(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement

Sometimes called the “individual mandate”, the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don’t have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance

Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace

A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an “Exchange”. The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

Health coverage that will meet the individual responsibility requirement. 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.

Minimum Value Standard

A basic standard to measure the percent of permitted costs the plan covers. If you’re offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Network

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called “preferred provider” or “participating provider.”

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the allowed amount for covered health care services to providers who don’t contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment

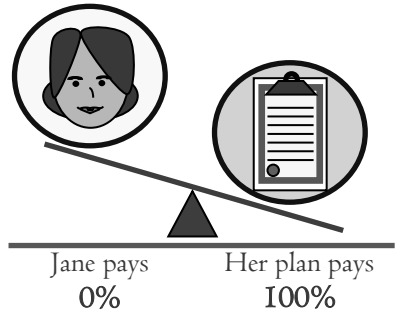
A fixed amount (for example, \$30) you pay for covered health care services from providers who do **not** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider".

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the



(See page 6 for a detailed example.)

allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral

A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is **not** the same as “skilled care services”, which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500

Coinsurance: 20%

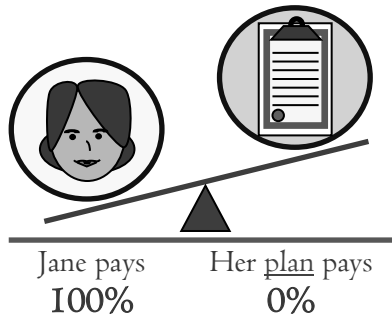
Out-of-Pocket Limit: \$5,000

January 1st

Beginning of Coverage Period

December 31st

End of Coverage Period



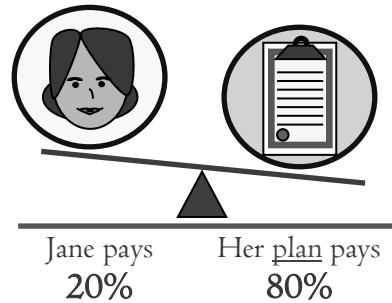
Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0



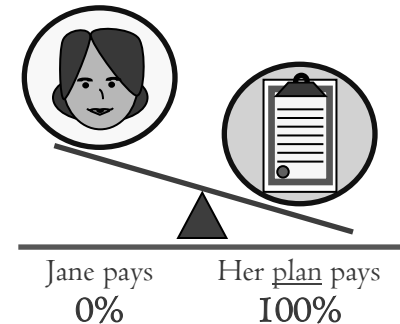
Jane reaches her \$1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid \$1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: \$125

Jane pays: 20% of \$125 = \$25

Her plan pays: 80% of \$125 = \$100



Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$125

Jane pays: \$0

Her plan pays: \$125