This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-855-272-4938.

This plan includes a Health Reimbursement Account to pay part or all of your deductible. Refer to your enrollment information for available amounts.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,000** Single/**$6,000** Family Network providers. **$3,500** Single/**$7,000** Family for Non Network providers.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always**, October 1st**). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible. **This plan includes a Health Reimbursement Account to pay part or all of your deductible. Refer to your enrollment information for available amounts.**
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,000** Single/ **$6,000** Family for Network providers. **$6,500** Single/**$13,000** Family for Non Network providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. **This plan includes a Health Reimbursement Account to pay part or all of your deductible. Refer to your enrollment information for available amounts.**
What is not included in the out–of–pocket limit?	Flat copayments & prescription drug copayments, Non Network Human Organ and Tissue Transplants, Premiums, Balance-billed charges, and Health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.anthem.com or 1-855-272-4938 for a list of	If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital

	Network providers.	may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred,** or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $25) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your Coinsurance payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments** and Coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**$25** Copay/Visit	**20%** Coinsurance after Deductible	——————none——————
	Specialist visit	**$35** Copay/Visit	**20%** Coinsurance after Deductible	——————none——————
	Other practitioner office visit	**$35** Copay/Visit for Chiropractor	**20%** Coinsurance after Deductible for Chiropractor	Coverage is limited to 26 visits per plan year combined network and Non Network providers for Chiropractor. Acupuncture is Not Covered. There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non Network Provider	Limitations & Exceptions
	Preventive care/screening/immunization	No Charges	**20%** Coinsurance	————none————
If you have a test	Diagnostic test (x-ray, blood work)	0% after deductible	**20%** Coinsurance after Deductible	————none————
	Imaging (CT/PET scans, MRIs)	0% after deductible	**20%** Coinsurance after Deductible	————none————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.anthem.com**.	Generic drugs	**$5** Copay/Prescription for Retail **$10** Copay/Prescription for Mail Service	**50%** Coinsurance for Retail	30-day supply for Retail. 90-day supply for Mail Service. Mail Service is Not Covered for Out of Network providers.
	Preferred brand drugs	**$30** Copay/Prescription for Retail **$60** Copay/Prescription for Mail Service	**50%** Coinsurance for Retail	30-day supply for Retail. 90-day supply for Mail Service. Mail Service is Not Covered for Out of Network providers.
	Non-preferred brand drugs	**$55** Copay/Prescription for Retail **$110** Copay/Prescription for Mail Service	**50%** Coinsurance for Retail	30-day supply for Retail. 90-day supply for Mail Service. Mail Service is Not Covered for Out of Network providers.
	Specialty drugs	**$55** Copay/Prescription	**50%** Coinsurance	30-day supply. .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% after deductible	**20%** Coinsurance after Deductible	————none————
	Physician/surgeon fees	0% after deductible	**20%** Coinsurance after Deductible	————none————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	**$200** Copay/Visit	**$200** Copay/Visit	If admitted, the ER copay is waived. Failure to obtain pre-authorization may result in non coverage or reduced benefits.
	Emergency medical transportation	0% after deductible	0% after deductible	————none————
	Urgent care	**$50** Copay/Visit	**0%** Coinsurance	Charges are reimbursed up to the allowable amount.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% after deductible	**20%** Coinsurance after Deductible	Failure to obtain pre-authorization may result in non coverage or reduced benefits.
	Physician/surgeon fee	0% after deductible	**20%** Coinsurance after Deductible	————none————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% after deductible	**20%** Coinsurance after Deductible	————none————
	Mental/Behavioral health inpatient services	0% after deductible	**20%** Coinsurance after Deductible	————none————
	Substance Abuse disorder outpatient services	0% after deductible	**20%** Coinsurance after Deductible	————none————
	Substance Abuse disorder inpatient services	0% after deductible	**20%** Coinsurance after Deductible	————none————
If you are pregnant	Prenatal and postnatal care	0% after deductible	**20%** Coinsurance after Deductible	————none————
	Delivery and all inpatient services	0% after deductible	**20%** Coinsurance after Deductible	Failure to obtain pre-authorization may result in non coverage or reduced benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	0% after deductible	**20%** Coinsurance after Deductible	——————none——————
	Rehabilitation services	**$25** Copay/Visit	**20%** Coinsurance after Deductible	Coverage is limited to 60 visits per calendar year for Physical, Speech and Occupational therapy, Cardiac Rehabilitation. There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Habilitation services	**$25** Copay/Visit	**20%** Coinsurance after Deductible	Coverage is limited to 60 visits per calendar year for Physical, Speech and Occupational therapy, Cardiac Rehabilitation. There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Skilled nursing care	0% after deductible	**20%** Coinsurance after Deductible	Coverage is limited to 90 days per calendar year combined Network and Non Network providers. Failure to obtain pre-authorization may result in non coverage or reduced benefits.
	Durable medical equipment	0% after deductible	**20%** Coinsurance after Deductible	——————none——————
	Hospice service	0% after deductible	**20%** Coinsurance after Deductible	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	**$25** Copay/Visit	**20%** Coinsurance after Deductible	Charges are reimbursed up to the allowable amount.
	Glasses	Not Covered	Not Covered	———————none———————
	Dental check-up	Not Covered	Not Covered	———————none———————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-272-4938. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Grandfathered Health Plan:

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the ACA). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1-855-272-4938.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:
Anthem Blue Cross Blue Shield; Attn Member Grievances and Appeals; P.O Box 105568, Atlanta, GA 30348-5568; Department of Labor's Employee Benefits Security

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage**.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides**.

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíílkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4420
- **Patient pays** $3120

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3,000
Copays	$70
Coinsurance	$0
Limits or exclusions	$150
Total	**$3120**

This plan includes a Health Reimbursement Account to pay part or all of your deductible. Refer to your enrollment information for available amounts

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,115
- **Patient pays** $3,285

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$3,000
Copays	$205
Coinsurance	$0
Limits or exclusions	$80
Total	**$3,285**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and Coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and Coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.