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 1-877-224-0030.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,300** Individual/**$2,600** Family for In-Network Providers. Includes pharmacy drugs Out-of-Network Providers: **Not Covered**	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, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
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. **$4,500** Individual/**$9,000** Family for In-Network Providers. Includes deductible. (Medical & Rx retail/mail combined) Out-of-Network Providers: **Not Covered**	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.
What is not included in the out–of–pocket limit?	Services deemed not medically necessary, Penalties for non-compliance, 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, this plan uses network providers. If you use a non-network provider your costs will not be covered. For a list of network providers, see www.anthem.com or 1-877-224-0030.	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 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 can see the **specialist** you choose without permission from this plan.
Are there services this	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or

Important Questions	Answers	Why this Matters:
plan doesn't cover?		plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) 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 In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**20%** Coinsurance After Deductible	Not Covered	--------none--------
	Specialist visit	**20%** Coinsurance After Deductible	Not Covered	--------none--------
	Other practitioner office visit	**20%** Coinsurance After Deductible	Not Covered	Chiropractor Coverage is limited to 20 visit/year.
	Preventive care/screening/immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law. Preventive care covered in network only.
If you have a test	Diagnostic test (x-ray, blood work)	**20%** Coinsurance After Deductible	Not Covered	--------none--------
	Imaging (CT/PET scans, MRIs)	**20%** Coinsurance	Not Covered	--------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].	Tier1 - Typically Generic	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Not Covered	Maintenance medications will take a 100% coinsurance at retail after the 3rd fill. Retail: 30 day supply Mail Order: 90 day supply
	Tier2 - Typically Preferred / Brand	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Not Covered	Maintenance medications will take a 100% coinsurance at retail after the 3rd fill. Retail: 30 day supply Mail Order: 90 day supply
	Tier3 - Typically Non-Preferred / Specialty Drugs	Retail: 20% Coinsurance Mail Order: 20% Coinsurance	Not Covered	Maintenance medications will take a 100% coinsurance at retail after the 3rd fill. Retail: 30 day supply Mail Order: 90 day supply
	Tier4 - Typically Specialty Drugs	Retail: Not Covered Mail Order: 20% Coinsurance	Not Covered	Specialty Medications need to be filled thru the Express-Scripts Accredo Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**20%** Coinsurance After Deductible	Not Covered	--------none--------
	Physician/surgeon fees	**20%** Coinsurance After Deductible	Not Covered	--------none--------
If you need immediate medical attention	Emergency room services	**20%** Coinsurance After Deductible; **50%** Coinsurance After Deductible if not a true emergency	**20%** Coinsurance After Deductible; **50%** Coinsurance After Deductible if not a true emergency	--------none--------
	Emergency medical transportation	**20%** Coinsurance After Deductible; **50%** Coinsurance After Deductible if not a true emergency	**20%** Coinsurance After Deductible; **50%** Coinsurance After Deductible if not a true emergency	--------none--------
	Urgent care	**20%** Coinsurance After Deductible	Not Covered	--------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	**20%** Coinsurance After Deductible	Not Covered	Failure to obtain pre-certification may result in a penalty of $500.
	Physician/surgeon fee	**20%** Coinsurance After Deductible	Not Covered	--------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**20%** Coinsurance After Deductible	Not Covered	EAP limited to 4 visits per calendar year; Pre-certification may be required for certain outpatient services.
	Mental/Behavioral health inpatient services	**20%** Coinsurance After Deductible	Not Covered	Failure to obtain pre-certification may result in a penalty of $500.
	Substance use disorder outpatient services	**20%** Coinsurance After Deductible	Not Covered	Pre-certification may be required for certain outpatient services.
	Substance use disorder inpatient services	**20%** Coinsurance After Deductible	Not Covered	Failure to obtain pre-certification may result in a penalty of $500.
If you are pregnant	Prenatal and postnatal care	**20%** Coinsurance After Deductible	Not Covered	--------none--------
	Delivery and all inpatient services	**20%** Coinsurance After Deductible	Not Covered	Failure to obtain pre-certification for childbirth if Inpatient stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery may result in a penalty of $500.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	**20%** Coinsurance After Deductible	Not Covered	Coverage is limited to 200 visits per Benefit Period including Private duty nursing. Failure to obtain pre-certification may result in non-coverage.
	Rehabilitation services	**20%** Coinsurance After Deductible	Not Covered	Coverage is limited to 100 visits per Benefit Period combined for Physical Therapy, Occupational Therapy, Speech Therapy and Vision Therapy.
	Habilitation services	**20%** Coinsurance After Deductible	Not Covered	Habilitation visits count towards your Rehabilitation limit.
	Skilled nursing care	**20%** Coinsurance After Deductible	Not Covered	Coverage is limited to 120 days per Convalescent Period. Failure to obtain pre-certification may result in a penalty of $500.
	Durable medical equipment	**20%** Coinsurance After Deductible	Not Covered	Failure to obtain pre-certification may result in non-coverage for purchase or rental over $1,000.
	Hospice service	**20%** Coinsurance After Deductible	Not Covered	Failure to obtain pre-certification may result in non-coverage.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Covered as part of preventive care. Not a complete eye exam. In network only.
	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.)

- Adult routine vision exam (i.e. refraction)
- Child dental check-up
- Child glasses
- Child routine vision exam (i.e. refraction)
- Cosmetic Surgery
- Dental Care (Adult)
- Long-term care
- Over the counter drugs or supplies
- Weight loss programs
- Services/supplies above the allowed amount or UCR
- Services/supplies paid by another plan under COB.
- Services/supplies that are experimental/investigational

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.)

- Acupuncture (limitations may apply)
- Bariatric surgery (limitations may apply)
- Chiropractic care (limitations may apply)
- Hearing aids (limitations may apply)
- Infertility treatment (limitations may apply)
- Routine foot care (limitations may apply)
- Private-duty nursing (limitations may apply)
- Non-emergency care when traveling outside the U.S.

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 1-877-224-0030. 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.

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 the plan at 1-877-224-0030. You may also contact:

Anthem BlueCross BlueShield
ATTN: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

Or Contact:

Department of Labor's Employee Benefits
Security Administration at
1-866-444-EBSA(3272) or
www.dol.gov/ebsa/healthreform

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:** $4,890
- **Patient pays:** $2,650

Sample care costs:

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:

Patient pays	
Deductibles	$1,300
Copays	$0
Coinsurance	$1,200
Limits or exclusions	$150
Total	**$2,650**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,230
- **Patient pays:** $2,170

Sample care costs:

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:

Patient pays	
Deductibles	$1,300
Copays	$0
Coinsurance	$790
Limits or exclusions	$80
Total	**$2,170**

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.