HP: Anthem BCBS CDHP w/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, visit **www.myhpbenefits.com** or call **1-800-890-3100**. 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.myhpbenefits.com** or by calling **1-800-890-3100** to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	Network providers $1,300 individual / $3,900 family	Out-of-network providers $1,950 individual / $5,850 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. **Note:** You may use your annual HP-funded Health Reimbursement Account (HRA) ($500 Employee Only/$1,000 Family) to reimburse eligible expenses towards meeting the overall deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.		You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network providers $3,150 individual / $9,450 family; for network pharmacy $2,300 individual / $4,600 family	Out-of-network providers $6,950 individual / $20,850 family; for out-of-network pharmacy $4,400 individual / $8,800 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, any penalty for failure to obtain pre-authorization, and health care this plan doesn't cover. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See **includedhealth.com/hp** or call **1-855-633-9251** for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	20% coinsurance	50% coinsurance	100% covered for preventive services in office or virtual through HP Health Hub (visit includedhealth.com/hp or call 1-855-633-9251).
	Specialist visit			
	Preventive care/screening/ immunization	No charge; deductible does not apply	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.caremark.com** or by calling CVS Caremark 1-844-740-0599.	Tier 1 Drugs	$10 copay/ prescription (retail) $20 copay/ prescription (mail)	Reimbursed at contracted rate less applicable copay or coinsurance (retail) Not covered (mail)	Covers up to a 30-day supply (retail); 90-day supply available at retail for maintenance medications; visit express-scripts.com or contact your pharmacy; 90-day supply available through mail order. Please see "Important Questions" regarding the plan's out-of-pocket limit. Tier 1 includes coverage for certain brand name drugs. Note: Tier 1 contraceptives, no charge. Generic oral contraceptives and brands with no generic alternatives, no charge. If you fill a brand-name prescription drug **(all tiers)** and that drug has a generic equivalent, you pay your normal share of the brand-name drug cost, plus the difference between the generic drug ingredient cost and the brand-name drug ingredient cost. Tier 4 drugs apply to erectile dysfunction medications and sleep aids. Fertility medication covered through Schraft's Pharmacy. For more information contact Kindbody at 1-855-499-3519.
	Tier 2 Drugs	30% coinsurance; $30 min./ $60 max./ prescription (retail) 2.5x retail 30-day copay/ prescription (mail)		
	Tier 3 Drugs	40% coinsurance; $45 min./ $90 max./ prescription (retail) 2.5x retail 30-day copay/ prescription (mail)		
	Tier 4 Drugs	50% coinsurance; $75 min./ $125 max./ prescription (retail) 2.5x retail 30-day copay/ prescription (mail)		

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance; deductible does not apply if true emergency	20% coinsurance; 50% coinsurance for non-emergency	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance; deductible does not apply	20% coinsurance; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	None
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance use services More information is available by calling 1-844-819-4773. To find a network provider, login to **www.guidanceresources.com**, click "Register" and use the Org Web ID "HP".	Outpatient services	20% coinsurance; deductible does not apply	50% coinsurance; deductible does not apply	Provider must be in the ComPsych network to receive the network provider benefit. For inpatient services, precertification is required.
	Inpatient services	10% coinsurance; deductible does not apply	40% coinsurance; deductible does not apply	
If you are pregnant	Office visits	Routine prenatal care no charge; otherwise, 20% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC

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)	
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	(i.e. ultrasound).
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 120 visits per calendar year combined in-network and out-of-network. Must be noncustodial.
	Rehabilitation services	20% coinsurance	50% coinsurance	Physical, occupational, and speech therapy each limited to 30 visits per calendar year combined in-network and out-of-network.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	10% coinsurance	40% coinsurance	Limited to 120 days per calendar year combined in-network and out-of-network. Must be prescribed and performed in a noncustodial facility.
	Durable medical equipment	20% coinsurance	50% coinsurance	Repair and maintenance covered also.
	Hospice services	Inpatient: 10% coinsurance Outpatient: 20% coinsurance	Inpatient: 40% coinsurance Outpatient: 50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Not covered	For preventive, routine eye exam.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic Surgery
- Dental Care
- Long Term Care
- Routine Foot Care
- Routine eye care (Adult)
- Weight Loss Programs

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

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility treatment (covered through Kindbody)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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: 1-866-444-EBSA (3272) or 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 Minimum Value Standards? **Yes**.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-890-3100.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-890-3100.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-890-3100.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-890-3100.

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	$1,300
Specialist copayment	20%
Hospital (facility) coinsurance	10%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$10
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,770**

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

The plan's overall deductible	$1,300
Specialist copayment	20%
Hospital (facility) coinsurance	10%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$300
Coinsurance	$1,00
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

The plan's overall deductible	$1,300
Specialist copayment	20%
Hospital (facility) coinsurance	10%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,610**

Note: These numbers do not reflect Health Reimbursement Account (HRA) balances.

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