

HP: Anthem BCBS EPO

Coverage for: All Tiers | Plan Type: EPO



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 ?	\$600 individual / \$1,200 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 .
Are there services covered before you meet your deductible ?	Yes. Preventive care and primary/specialty 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 ?	For medical \$4,500 individual / \$9,000 family; includes deductible and copays; includes Rx and MH/SU	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.
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 .

Important Questions	Answers	Why This Matters:
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 . This plan will not pay if you use an out-of-network provider . 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 copay /visit; deductible does not apply	Not covered	100% covered for preventive services virtually through Included Health (visit includedhealth.com/hp or call 1-855-633-9251).
	Specialist visit	\$45 copay /visit; deductible does not apply	Not covered	
	Preventive care/screening /Immunization	No charge; deductible does not apply	Not covered	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)	10% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	

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 at 1-844-740-0599	Tier 1 Drugs	\$10 copay / prescription (retail) \$20 copay / prescription (mail)	Not covered (retail and 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 oral 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)		

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)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	\$200 copay, then 10% coinsurance	\$200 copay, then 10% coinsurance	Emergency room copay waived if admitted as hospital inpatient.
	Emergency medical transportation	No charge; deductible does not apply	No charge; deductible does not apply	For true emergency; non-emergency covered only when part of a monitored, preauthorized care plan.
	Urgent care	\$50 copay /visit; deductible does not apply	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	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 copay /visit; deductible does not apply	Not covered	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	Not covered	
If you are pregnant	Office visits	Routine prenatal care no charge; otherwise, \$20 PCP/\$45 specialist	Not covered	Cost sharing does not apply to certain preventive services . Depending on the type of services; a copayment , coinsurance or

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)	
		copay /visit; deductible does not apply		deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	Not covered	
	Childbirth/delivery facility services	10% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge; deductible does not apply	Not covered	Limited to 120 visits per calendar year. Must be noncustodial.
	Rehabilitation services	Office visit: \$45 specialist copay /visit; deductible does not apply Outpatient facility: 10% coinsurance	Not covered	Physical, occupational, and speech therapy each limited to 30 visits per calendar year.
	Habilitation services	Office visit: \$45 specialist copay /visit; deductible does not apply Outpatient facility: 10% coinsurance	Not covered	
	Skilled nursing care	10% coinsurance	Not covered	Limited to 120 days per calendar year. Must be prescribed and performed in a noncustodial facility.
	Durable medical equipment	No charge; deductible does not apply	Not covered	Repair and maintenance covered also.
	Hospice services	No charge; deductible does not apply	Not covered	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](#).)

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

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

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

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, kwijigo 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	\$600
■ Specialist copayment	\$45
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$10
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,870

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$600
■ Specialist copayment	\$45
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$620

Mia's Simple Fracture

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

■ The plan's overall deductible	\$600
■ Specialist copayment	\$45
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$500
Coinsurance	\$50
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$750