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 (833)592-9956 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Calendar Year deductible?	**$0**/member or **$0**/family for In-**Network Providers**. **$500**/ member or **$1,000**/family for Out-of-**Network Providers**.	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. In-Network Preventive care and annual Vision exam for In-Network Providers.	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 Medical/Drug out-of-pocket limit for this plan?	**$5,000**/ member or **$10,000**/family for In-**Network Providers**. **$6,500**/ member or **$13,000**/family for Out-of-**Network Providers**.	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?	Cost share of adult routine vision care, **Premiums**, **Balanced-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**.
Will you pay less if you use a network provider?	Yes, KeyCare. See www.anthem.com or call (833)592-9956for 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

All **coinsurance** costs shown in this chart are after your **deductible** has been met.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	$30 copay/visit	30% coinsurance	--------none--------
	Specialist visit	$50 copay/visit	30% coinsurance	--------none--------
	Preventive care/**screening**/immunization	No cost share	30% coinsurance	You may have to pay for services that aren't preventive. Ask your **provider** if the services you need are preventive.
If you have a test	**Diagnostic test** (x-ray, blood work)	20% coinsurance	30% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Preauthorization required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.express-scripts.com	Tier 1 - Typically Generic	$15/prescription (retail) and $38/prescription (home delivery)	$15/prescription (retail) (no home delivery)	Pharmacy member cost shares count towards the combined Medical/Drug out-of-pocket maximum. Most Retail pharmacy drugs are limited to a 30-day supply. Mail order drugs are limited to a 90-day day supply. In-network you can get a 90 day supply of retail maintenance drugs for 3x the Retail 30 day supply copay. Your plan uses a preferred drug list (formulary). **Self-administered Specialty drugs must be dispensed by IngenioRx** Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements.
	Tier 2 - Typically Preferred/ Brand	$40/prescription (retail) and $100/prescription (home delivery)	$40/prescription (retail) (no home delivery)	
	Tier 3 - Typically Non-Preferred Brand	$75/prescription (retail) and $188/prescription (home delivery)	$75/prescription (retail) (no home delivery)	
	Tier 4 - Typically Specialty Drugs (Only self-administered specialty drugs covered under pharmacy benefit. **Clinician/Physician administered specialty drugs are covered under the Medical plan**.)	20% coinsurance up to $200/30 day day fill $400/90 day fill (retail and home delivery)	n/a	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay+20% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	No cost share	30% coinsurance	--------none--------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$200 copay+20% coinsurance	20% coinsurance	--------none--------
	Emergency medical transportation	$150 copay/transport	20% coinsurance	--------none--------
	Urgent care	$30 PCP/$50 Spec. copay/visit	30% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay+20% coinsurance	30% coinsurance	Precertification required.
	Physician/surgeon fee	20% coinsurance	30% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse needs	Outpatient services	Office Visit $30 copay/visit Other Outpatient 20% coinsurance	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	--------none--------
	Inpatient services	$300 copay+20% coinsurance	30% coinsurance	Precertification required.
If you are pregnant	Office visits	$200 copay/pregnancy (global billed services)	30% coinsurance	$200 copay for OB Dr. global billed services covering pre- and post-natal care and delivery. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasounds).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	$300 copay+20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	$30 copay/visit	30% coinsurance	100 visits/per calendar year.
	Rehabilitation services	**Physical Therapy**: $50 copay+ 20% coinsurance **Speech/Occupational Therapy:** 20% coinsurance	30% coinsurance	There is a 30-visit limit for physical and occupational therapy, combined. 30-visit limit for speech therapy. Early Intervention Services Pre-determination of eligibility required.
	Habilitation services	Same as above	30% coinsurance	
	Skilled nursing care	20% coinsurance	30% coinsurance	100 day per stay limit; pre-authorization required.
	Durable medical equipment	20% coinsurance	30% coinsurance	——————none——————
	Hospice service	No cost share	30% coinsurance	——————none——————
If your child needs dental or	Children's eye exam	$15/visit	$30 allowance	One routine exam per calendar year
	Children's glasses	Not covered	Not covered	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
eye care	Children's 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
Cosmetic surgery
Dental care
Hearing aids
Infertility treatment
Long-term care
Routine foot care other than for Diabetes
Weight loss programs
Morbid Obesity services

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

Chiropractic care 30 visits/benefit period.
Adult Routine Eye Exams
Autism Spectrum Disorder
Coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
Routine eye care (adult)

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's Employee Benefits Security Administration at 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:

ATTN: Anthem **Grievance** and **Appeals** P.O. Box 27401, Atlanta, Richmond, VA 23279.

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? 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.

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*	$00
■ Specialist *copayment*	$50
■ Hospital (facility) *coinsurance*	20%
■ 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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$450
Coinsurance	$2,478
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,928**

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

■ The plan's overall *deductible*	$0
■ Specialist *copayment*	$50
■ Hospital (facility) *coinsurance*	20%
■ 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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$1,312
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,212**

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

■ The plan's overall *deductible*	$0
■ Specialist *copayment*	$50
■ Hospital (facility) *coinsurance*	20%
■ 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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$362
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$562**

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

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 1-833-592-9956 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Calendar Year deductible?	**$2,000**/member or **$4,000**/family for In-**Network Providers**. **3,000**/ member or **$6,000**/family for Out-of-**Network Providers**.	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. In-Network Preventive care and annual Vision exam for In-Network Providers.	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 Medical/Drug out-of-pocket limit for this plan?	**$5,000**/ member or **$10,000**/family for In-**Network Providers**. **$7,250**/ member or **$14,500**/family for Out-of-**Network Providers**.	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?	Cost share of adult routine vision care, **Premiums**, **Balanced-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**.
Will you pay less if you use a network provider?	Yes, KeyCare. See www.anthem.com or call 1-833-592-9956 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

All **coinsurance** costs shown in this chart are after your **deductible** has been met.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	$30 copay/visit	40% coinsurance	--------none--------
	Specialist visit	$50 copay/visit	40% coinsurance	--------none--------
	Preventive care/**screening**/immunization	No cost share	40% coinsurance	You may have to pay for services that aren't preventive. Ask your **provider** if the services you need are preventive.
If you have a test	**Diagnostic test** (x-ray, blood work)	20% coinsurance	40% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com	Tier 1 - Typically Generic	$15/prescription (retail) and $38/prescription (home delivery)	$15/prescription (retail) (no home delivery)	Pharmacy member cost shares count towards the combined Medical/Drug out-of-pocket maximum. Most Retail pharmacy drugs are limited to a 30-day supply. Mail order drugs are limited to a 90-day day supply. In-network you can get a 90 day supply of retail maintenance drugs for 3x the Retail 30 day supply copay. Your plan uses a preferred drug list (formulary). **Self-administered Specialty drugs must be dispensed by IngenioRx.** Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements.
	Tier 2 - Typically Preferred/ Brand	$40/prescription (retail) and $100/prescription (home delivery)	$40/prescription (retail) (no home delivery)	
	Tier 3 - Typically Non-Preferred Brand	$75/prescription (retail) and $188/prescription (home delivery)	$75/prescription (retail) (no home delivery)	
	Tier 4 - Typically Specialty Drugs (Only self-administered specialty drugs covered under pharmacy benefit. **Clinician/Physician administered specialty drugs are covered under the Medical plan.**)	20% coinsurance up to $200/30 day day fill $400/90 day fill (retail and home delivery)	n/a	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	--------none--------
	Physician/surgeon fees	No cost share	40% coinsurance	--------none--------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	**Emergency room care**	20% coinsurance	20% coinsurance	--------none--------
	Emergency medical transportation	20% coinsurance	20% coinsurance	--------none--------
	Urgent care	$30 PCP/$50 Spec. copay/visit	40% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification required.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse needs	Outpatient services	Office Visit $30 copay/visit Other Outpatient 20% coinsurance	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	--------none--------
	Inpatient services	20% coinsurance	40% coinsurance	Precertification required.
If you are pregnant 27	Office visits	$30 PCP/$50 Spec. copay/visit (non-global billed services)	40% coinsurance	Routine pre/post-natal care (excluding inpatient stay & diagnostic testing). Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasounds).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	**Home health care**	**20% coinsurance**	40% coinsurance	100 visits/per calendar year.
	Rehabilitation services	20% coinsurance	40% coinsurance	There is a 30-visit limit for physical and occupational therapy, combined. 30-visit limit for speech therapy. Early Intervention Services Pre-determination of eligibility required.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	100 day per stay limit; pre-authorization required.
	Durable medical equipment	20% coinsurance	40% coinsurance	——————none——————
	Hospice service	No cost share	40% coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	$15/visit	$30 allowance	One routine exam per calendar year
	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 Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

Acupuncture
Cosmetic surgery
Dental care
Hearing aids
Infertility treatment
Long-term care
Routine foot care other than for Diabetes
Weight loss programs
Morbid Obesity services

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

Chiropractic care 30 visits/benefit period.
Adult Routine Eye Exams
Autism Spectrum Disorder
Coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
Routine eye care (adult)

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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? 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.

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*	$2,000
■ Specialist *copayment*	$50
■ Hospital (facility) *coinsurance*	20%
■ 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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$150
Coinsurance	$2,138
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,288**

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

■ The plan's overall *deductible*	$2,000
■ Specialist *copayment*	$50
■ Hospital (facility) *coinsurance*	20%
■ 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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$900
Coinsurance	$912
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,812**

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

■ The plan's overall *deductible*	$2,000
■ Specialist *copayment*	$50
■ Hospital (facility) *coinsurance*	20%
■ 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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$2
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,002**

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

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/fi. 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 (833)592-9956 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Calendar Year deductible?	**$3,000**/single or **$6,000**/family ($3,000 Individual) for In-Plan Providers and Out-of-Network Providers combined.	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 annual Vision exam for In-Plan Providers.	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?	**$4,000**/single; **$8,000**/family for In-Plan Providers. **$6,000**/single; **$12,000**/family for Out-of-Network Providers.	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 Calendar Year out-of-pocket limit?	Premiums, Balance-Billing 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.
Will you pay less if you use a network provider?	Yes, KeyCare. See www.anthem.com or call (833)592-9956 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
		In-Plan Provider (You will pay the least)	Out-Of-Plan- 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% coinsurance	20% coinsurance	--------none--------
	Specialist visit	0% coinsurance	20% coinsurance	--------none--------
	Preventive care/screening/ immunization	No cost share	20% coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 0% coinsurance X-Ray – Office 0% coinsurance	Lab – Office 20% coinsurance X-Ray – Office 20% coinsurance	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	$10/prescription (retail) and $25/prescription (home delivery)	$10/prescription (retail) (no home delivery)	***Copays & Coinsurance apply after Deductible.*** In-network you can get a 90 day supply of retail maintenance drugs for 3x the Retail 30 day supply copay. Some drugs may require prior authorization, while other drugs are subject to step therapy and quantity limit requirements. Must use IngenioRx pharmacy. Out of network you'll be responsible for amounts over the allowable.
	Tier 2 - Typically Preferred/ Brand	$30/prescription (retail) and $75/prescription (home delivery)	$30/prescription (retail) (no home delivery)	
	Tier 3 - Typically Non-Preferred	$50/prescription (retail) and $125/prescription (home delivery)	$50/prescription (retail) (no home delivery)	
	Tier 4 - Typically Specialty Drugs (Self-Injectable only)	20% coinsurance up to $200/prescription (retail and home delivery)	n/a	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	--------none--------
	Physician/surgeon fee	0% coinsurance	20% coinsurance	
If you need immediate medical attention	Emergency room care	0% coinsurance	Covered as In-Network*	--------none--------
	Emergency medical transportation	0% coinsurance	Covered as In-Network*	--------none--------
	Urgent care	0% coinsurance	20% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Pre-auth required
	Physician/surgeon fees	0% coinsurance	20% coinsurance	--------none--------

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Plan Provider (You will pay the least)	Out-Of-Plan- Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 0% coinsurance Other Outpatient 0% coinsurance	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	0% coinsurance	20% coinsurance	--------none--------
If you are pregnant	Office visits	0% coinsurance	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	100 visits/benefit period.
	Rehabilitation services	0% coinsurance	20% coinsurance	Visit limits apply.
	Habilitation services	0% coinsurance	20% coinsurance	
	Skilled nursing care	0% coinsurance	20% coinsurance	100 day limit/stay.
	Durable medical equipment	0% coinsurance	20% coinsurance	--------none--------
	Hospice services	0% coinsurance	20% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	$15/copay	No charge up to $30/occurrence	One routine exam per calendar year
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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
- Cosmetic surgery
- Long- term care
- Dental care (children & adults)
- Infertility treatment
- Morbid Obesity services
- Hearing aids
- Routine foot care other than for Diabetes
- Weight loss programs

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

- Autism Spectrum Disorder
- Most coverage provided outside the United States www.bcbs.com/bluecardworldwide
- Routine eye care (adult) Coverage is limited to Routine vision exam per calendar year

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

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's Employee Benefits Security Administration at (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:

ATTN: Grievances and Appeals, P.O. Box 27401, Richmond, VA 23279

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

Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945

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/fi.

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	**$3,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services

Specialist visit *(anesthesia)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
RxCopayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,100**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The plan's overall deductible	**$3,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*

Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
RxCopayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$4,000**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible	**$3,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

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

Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,010
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,010**

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