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 1-855-333-5735.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** single / **$1000** family for In-Network Provider **$750** single / **$1500** family for Non-Network Provider Does not apply to In-Network Preventive Care, Copayments and Routine Eye Exam. In-Network Provider and Non-Network Provider deductibles are separate and do not count towards each other.	You must pay all the costs up to the **deductible** amount before this health insurance 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 3 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 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; In-Network Provider Single: **$3000**, Family: **$6000** Non-Network Provider Single: **$4500**, Family: **$9000**	The **out-of-pocket limit** is the most you could pay during a policy period 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?	Balance-Billed Charges, Health Care This Plan Doesn't Cover, Premiums, Routine Vision Care.	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. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 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. For a list of preferred providers, see www.anthem.com or call 1-855-333-5735.	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. Plans use the terms in-network, preferred, or participating to refer to providers in their network.

Do I need a referral to see a specialist?	No, you do not need a referral to see a specialist.	You can see a specialist you choose for covered services 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, $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 In-Network Providers	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	$25 copay/visit	40% coinsurance	In network: Not subject to the deductible.
	Specialist visit	$50 copay/visit	40% coinsurance	In network: Not subject to the deductible.
	Other practitioner office visit	Manipulative Therapy: $25 copay/visit	Manipulative Therapy: 40% coinsurance	Manipulative limited to 30 visits per member per calendar year. In-network: Not subject to the deductible.
	Preventive care/screening/immunization	No charge	40% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	Lab: 20% coinsurance X-ray: 20% coinsurance	Lab: 40% coinsurance X-ray: 40% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use In-Network Providers	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Precertification required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com	Tier 1 – Typically Generic	**$10** copay for up to 30-day supply from a participating pharmacy. **$20** copay for up to a 90-day supply delivered to your home.	**$10** copay for up to 30-day supply from a participating pharmacy. **$20** copay for up to a 90-day supply delivered to your home.	Retail pharmacy drugs are limited to a 30-day supply. Mail order drugs are limited to a 90-day supply. Your plan uses a preferred drug list (formulary) which identifies the status of covered drugs. Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements. If the necessary preauthorization is not obtained, the drug may not be covered. Note that if you visit an out-of-network pharmacy, you will pay the full cost of your prescription at the pharmacy then file a claim for reimbursement. Reimbursement will be based on what a participating pharmacy would receive had the prescription been filled at a participating pharmacy. Specialty drugs must be purchased through the Specialty Pharmacy.
	Tier 2 – Typically Preferred/Formulary Brand	**$40** copay for up to 30-day supply from a participating pharmacy. **$80** copay for up to a 90-day supply delivered to your home	**$40** copay for up to 30-day supply from a participating pharmacy. **$80** copay for up to a 90-day supply delivered to your home	
	Tier 3 – Typically Non-Preferred/Non-Formulary and Specialty Drugs	**$75** copay for up to 30-day supply from a participating pharmacy. **$150** copay for up to a 90-day supply delivered to your home	**$75** copay for up to 30-day supply from a participating pharmacy. **$150** copay for up to a 90-day supply delivered to your home	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————-

Common Medical Event	Services You May Need	Your Cost If You Use In-Network Providers	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	$25 PCP/$50 specialist copay/visit	40% coinsurance	In-network: Not subject to the deductible. 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.
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——————

Common Medical Event	Services You May Need	Your Cost If You Use In-Network Providers	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit: $25 copay Mental/Behavioral Health Facility Visit - Facility Charges: 20% coinsurance	Mental/Behavioral Health Office Visit: 40% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges: 40% coinsurance	Mental/Behavioral Health Office Visit: In-network office visit: Not subject to the deductible.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Precertification required.
	Substance use disorder outpatient services	Substance Abuse Office Visit: $25 copay Substance Abuse Facility Visit - Facility Charges: 20% coinsurance	Substance Abuse Office Visit: 40% coinsurance Substance Abuse Facility Visit - Facility Charges: 40% coinsurance	Substance Abuse Office Visit: In-network office visit: Not subject to the deductible.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Precertification required.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Applies to inpatient facility. Other cost shares may apply depending on services provided.

Common Medical Event	Services You May Need	Your Cost If You Use In-Network Providers	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	40% coinsurance	Coverage is limited to 100 visits per year.
	Rehabilitation services	20% coinsurance	40% coinsurance	30 visits for physical therapy and occupational therapy combined. 30 visits for speech therapy. Services from In-Network Provider and Non-Network Provider count towards your limit.
	Habilitation services	20% coinsurance	40% coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	20% Coinsurance	40% coinsurance	100 day per stay limit. Services from In-Network Provider and Non-Network Provider count towards your limit.
	Durable medical equipment	20% Coinsurance	40% coinsurance	——————none——————
	Hospice service	No charge	40% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	$15 copay/ visit	$30 allowance	One eye exam per member per calendar year. Provided through Blue View Vision. Not subject to deductible.
	Glasses	Not covered	Not covered	Discounts available on eyewear and lenses at participating providers.
	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
- 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 (limited to 30 visits)
- Routine eye care. Coverage is limited to 1 screening exam annually.
- Private duty nursing (limited to 16 hours per member per calendar year)
- Most coverage provided outside the United States. See www.BCBS.com/bluecardworldwide .

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 Human Resources at 540-434-9916.

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 and Blue Shield: Appeals, Attention Member Services, P.O. Box 27401, Richmond, VA 23279.

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 naabídíiłkiid. 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** $5,540
- **Patient pays** $2,000

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	$500
Copays	$0
Coinsurance	$1,350
Limits or exclusions	$150
Total	**$2,000**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,760
- **Patient pays** $1,640

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	$500
Copays	$820
Coinsurance	$240
Limits or exclusions	$80
Total	**$1,640**

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.