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 1-800-451-1527.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network: **$500** individual/ **$1000** family; For out-of-network: **$1000** per individual/ **$2000** per family.	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. For in-plan services **$3,500** individual / **$7,000** family For out-of-plan services **$5,250** individual / **$10,500** family	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?	Premiums, balance-billed charges, vision services, prescription drugs copays 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. For a list of **in-plan providers**, see www.anthem.com or call 1-855-333-5375.	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 do not need to get permission to see a specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. 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-plan providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-plan Provider	Your Cost If You Use an Out-of-plan 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	**30**% coinsurance	——————none——————
	Specialist visit	**$50** copay	**30%** coinsurance	——————none——————
	Other practitioner office visit	**Manipulative Therapy** **$25** Copay **Acupuncturist** Not Covered	**Manipulative Therapy** 30% coinsurance **Acupuncturist** Not Covered	**Manipulative Therapy** Not subject to the deductible. Coverage is limited to 30 visits per year per member. Failure to obtain preauthorization may result in non-coverage or reduced coverage. Services must be received by provider that participates in the American Specialty Health Network (ASHN).
	Preventive care/screening/immunization	No cost share	**30%** coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-plan Provider	Your Cost If You Use an Out-of-plan Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	**Lab-Office** **30%** Coinsurance **X-Ray-Office** **30%** Coinsurance	**Lab-Office** **30%** Coinsurance **X-Ray-Office** **30%** Coinsurance	**Lab-Office** Copay does not apply when services are provided by the same provider on the same day as the office visit. A Specialist copay may apply. **X-Ray-Office** Copay does not apply when services are provided by the same provider on the same day as the office visit. A Specialist copay may apply.
	Imaging (CT/PET scans, MRIs)	**30%** coinsurance	**30%** coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage
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/ Prescription for Retail Pharmacy and Home Delivery		Covers up to a 30 day supply (retail pharmacy), Covers up to a 90 day supply (home delivery program) If the member selects a brand drug when a generic equivalent is available the member is responsible for the generic copay plus the cost difference between the generic and brand equivalent even if the physician indicates no substitutions. If you have a prescription filled at a non-participating pharmacy, you must complete and submit a claim form. Reimbursements are based on the negotiated rate and may be subject to balance billing, edits, and exclusions. $3,500 per member and $12,700 per family out-of-pocket annual maximum.
	Tier 2 – Typically Preferred/Formulary Brand	**$30** Copay/ Prescription for Retail Pharmacy; **$60** Copay/ Prescription for Home Delivery		
	Tier 3 – Typically Non-preferred/Non-formulary and Specialty Drugs	The greater of **$50** Copay/Prescription or **20%** Coinsurance with a **$200** prescription maximum for Retail Pharmacy; The greater of **$150** Copay/Prescription or **20%** Coinsurance with a **$400** prescription maximum for Home Delivery		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**30%** coinsurance	**30%** coinsurance	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use an In-plan Provider	Your Cost If You Use an Out-of-plan Provider	Limitations & Exceptions
	Physician/surgeon fees	**30%** coinsurance	**30%** coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	**30%** coinsurance	**30%** coinsurance	No coverage for non emergency use of emergency room. Waived if admitted directly to hospital.
	Emergency medical transportation	**30%** coinsurance	**30%** coinsurance	——————none——————
	Urgent care	**$25** or **$50** copay	**30%** coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	**30%** coinsurance	**30%** coinsurance	Failure to obtain preauthorization may result in con-coverage or reduced coverage. Copay waived if readmitted for the same condition within less than 72 hours from discharge.
	Physician/surgeon fee	**30%** coinsurance	**30%** coinsurance	——————none——————
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** **30%** coinsurance	**Mental/Behavioral Health Office Visit** **30%** coinsurance **Mental/Behavioral Health Facility Visit-Facility Charges** **30%** coinsurance	**Mental/Behavioral Health Office Visit** Medication management, individual therapy up to 30 minutes and group therapy sessions at - $20 copay.
	Mental/Behavioral health inpatient services	**30%** coinsurance	**30%** coinsurance	——————none——————
	Substance use disorder outpatient services	**Substance Abuse Office Visit** **$25** copay **Substance Abuse Facility Visit-Facility Charges** No cost share	**Substance Abuse Office Visit** **30%** coinsurance **Substance Abuse Facility Visit-Facility Charges** **30%** coinsurance	**Substance Abuse Health Office Visit** Not subject to the deductible.
	Substance use disorder inpatient services	**30%** coinsurance	**30%** coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-plan Provider	Your Cost If You Use an Out-of-plan Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	**30%** coinsurance	**30%** coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	**30%** coinsurance	**30%** coinsurance	Copay waived if readmitted for the same condition within less than 72 hours from discharge.
If you need help recovering or have other special health needs	Home Health Care	**30%** coinsurance	**30%** coinsurance	Coverage is limited to 100 visits per year.
	Rehabilitation services	**30%** coinsurance	**30%** coinsurance	Coverage is limited to 30 combined visits per year for Physical and Occupational therapy, 30 visits per year for Speech therapy. Limit does not apply to autism services, if applicable. Services from In-Network Provider and Non-Network Provider count towards your limit.
	Habilitation services	**30%** coinsurance	**30%** coinsurance	Rehabilitation and Habilitation visits count toward your Rehabilitation visit limit.
	Skilled nursing care	**30%** coinsurance	**30%** coinsurance	Coverage is limited to 100 days per stay. Services from In-Network Provider and Non-Network Provider count towards your limit.
	Durable medical equipment	**30%** coinsurance	**30%** coinsurance	——————none——————
	Hospice service	No cost share	**30%** coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	$15 copayment	$30 allowance	——————none——————
	Glasses	Not Covered	Not Covered	Discounts are available.
	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
- Non-emergency care when traveling outside the U.S.
- 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
- Coverage provided outside the United States. (Emergency services only) 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 the plan at 800-833-5735. 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:

Anthem Blue Cross and BlueShield
Attention: Corporate Appeals Department
P.O. Box 27401
Richmond, VA 23279

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

Additionally, a consumer assistance program can help you file your appeal. Contact:

Virginia State Corporation Commission
Life & Health Division, Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
(877) 310-6560
http://www.scc.virginia.gov/boi
bureauofinsurance@scc.virginia.gov

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** $4,840
- **Patient pays** $2,700

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	$20
Coinsurance	$2,030
Limits or exclusions	$150
Total	**$2,700**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,840
- **Patient pays** $1,560

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	$630
Coinsurance	$350
Limits or exclusions	$80
Total	**$1,560**

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.