**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 https://eoc.anthem.com/eocdps/aso or by calling 1-855-593-8123.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible? | **$500** Individual/**$1,000** Family for In-Network Providers. **$1,500** Individual/**$3,000** Family for Out-of-Network Providers. In-Network Provider and Out-of-Network Provider deductibles are combined. Satisfying one helps satisfy the other. | 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? | Yes, prescription drug deductible **$100** single/**$200** family. | You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| Is there an out–of–pocket limit on my expenses? | Yes. **$3,000** Individual/**$6,000** Family for In-Network Providers. **$6,000** Individual/**$12,000** Family for Out-of-Network Providers. In-Network Provider and Out-of-Network Provider out-of-pocket are combined. Satisfying one helps satisfy the other. Prescription Drug Out-of-Pocket Limit **$1,500** Individual/ **$3,000** 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? | Services deemed not medically necessary by Medical Management and/or Anthem, Premiums, Balance-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. |
| 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. See www.anthem.com or call 1-855-593-8123 for a list of In-Network Providers. | 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 don't need a referral to see a specialist. | You can see the specialist you choose 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 an In-Network Provider | 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 | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | --------none-------- |
| | Specialist visit | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | --------none-------- |
| | Web Dr. Visit via LiveHealth Online | $49 until Deductible is satisfied, then 20% Coinsurance, or $9.80 | N/A – All providers available via LiveHealth Online participate with Anthem BCBS | --------none-------- |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Other practitioner office visit | Chiropractic Therapy<br>20% Coinsurance, after deductible<br>Acupuncture<br>20% Coinsurance, after deductible | Chiropractic Therapy<br>40% Coinsurance, after deductible<br>Acupuncture<br>40% Coinsurance, after deductible | Chiropractic Therapy<br>Coverage is limited to 20 visits per Benefit Period combined In-Network and Out-of-Network Providers.<br>Acupuncture: Must be administered by a medical doctor or a licensed acupuncturist |
| | Preventive care/screening/ immunization | No Cost Share | No Cost Share for the first $250, then covered at 40% Coinsurance | Immunizations: 40% Coinsurance for Out-of-Network Providers. |
| If you have a test | Diagnostic test (x-ray, blood work) | Lab – Office<br>20% Coinsurance, after deductible<br>X-Ray – Office<br>20% Coinsurance, after deductible | Lab – Office<br>40% Coinsurance, after deductible<br>X-Ray – Office<br>40% Coinsurance, after deductible | --------none-------- |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | --------none-------- |
| If you need drugs to treat your illness or condition<br><br>More information about prescription drug coverage is available at www.citibenefitsonline.com | Generic drugs | $~~5~~ 10 copay (retail) / $~~12.50~~20 (mail order), after deductible | 50% covered, after deductible | Covers up to 34-day supply (retail); 90-day supply (mail order) |
| | Preferred brand drugs | $30 copay (retail) / $75 copay (mail order), after deductible | 50% covered, after deductible | Covers up to 34-day supply (retail); 90-day supply (mail order) |
| | Non-preferred brand drugs | 50% covered - $50 min./$150 max copay (retail) / 50% covered $125 min./$375 max. (mail order), after deductible | 50% covered, after deductible | Covers up to 34-day supply (retail); 90-day supply (mail order) |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Specialty drugs | $~~5~~ 20 copay (generic), 75% covered - $50 min./$150 max copay (preferred brand), 50% covered - $100 min./$ 250 max. copay (non-preferred brand), after deductible | Not covered | Covers up to ~~34~~30-day supply |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | Pre-certification is required. |
| | Physician/surgeon fees | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | Precertification is required for certain procedures. |
| If you need immediate medical attention | Emergency room services | 20% Coinsurance, after deductible | ~~40~~20% Coinsurance, after deductible | ER cost share is not waived if admitted to the hospital.<br>Failure to obtain pre authorization within 48 hours of an emergency admission may result in non coverage or reduced benefits. |
| | Emergency medical transportation | No Cost Share | No Cost Share | For transport to and from the nearest medical facility qualified to give the required treatment.<br>Failure to obtain pre authorization may result in non-coverage for Air Ambulance. |
| | Urgent care | 20% Coinsurance, after deductible | 20% Coinsurance, after deductible | --------none-------- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | Pre-certification required. |
| | Physician/surgeon fee | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | --------none-------- |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | 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 | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | --------none-------- |
| | Mental/Behavioral health inpatient services | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | Pre-certification required. |
| | Substance use disorder outpatient services | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | --------none-------- |
| | Substance use disorder inpatient services | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | Pre-certification required. |
| If you are pregnant | Prenatal and postnatal care | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | --------none-------- |
| | Delivery and all inpatient services | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | Failure to obtain pre-authorization if inpatient stay exceeds 48 hours for normal delivery and 96 hours after a cesarean delivery may result in non-coverage or reduced benefits. Applies to inpatient facility. Other cost shares may apply depending on the services provided. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | 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, after deductible | 40% Coinsurance, after deductible | Coverage is limited to 200 visits per Benefit Period combined In-Network and Out-of-Network Providers, including Private duty nursing.<br>Additional visits may be covered if medically necessary.<br>Failure to obtain pre-authorization after 200 visits may result in non coverage. |
| | Rehabilitation services | Physical and occupational therapy: 20% coinsurance, after deductible first 60 visits; 30% coinsurance, after deductible thereafter with medical necessity review<br><br>Speech therapy: 20% coinsurance, after deductible first 90 visits; 30% Coinsurance, after deductible thereafter with medical necessity review | Physical and occupational therapy: 40% coinsurance, after deductible first 60 visits; 50% Coinsurance, after deductible thereafter with medical necessity review<br><br>Speech therapy: 40% coinsurance, after deductible first 90 visits; 50% Coinsurance, after deductible thereafter with medical necessity review | Coverage is limited to 60 visits per calendar year for Physical and Occupational Therapy combined, 90 visits per calendar year for Speech Therapy. Additional visits subject to medical necessity review and approval. Visit maximum is combined in and out of network. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Habilitation services | Physical and occupational therapy: 20% coinsurance, after deductible first 60 visits; 30% Coinsurance, after deductible thereafter with medical necessity review<br><br>Speech therapy: 20% coinsurance, after deductible first 90 visits; 30% Coinsurance, after deductible thereafter with medical necessity review | Physical and occupational therapy: 40% coinsurance, after deductible first 60 visits; 50% Coinsurance, after deductible thereafter with medical necessity review<br><br>Speech therapy: 40% coinsurance, after deductible first 90 visits; 50% Coinsurance, after deductible thereafter with medical necessity review | Coverage is limited to 60 visits per calendar year for Physical and Occupational Therapy combined, 90 visits per calendar year for Speech Therapy. Additional visits subject to medical necessity review and approval. Visit maximum is combined in and out of network. |
| | Skilled nursing care | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | Coverage is limited to 120 days per Benefit Period combined In-Network and Out-of-Network Providers.<br>Pre-certification required. |
| | Durable medical equipment | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | --------none-------- |
| | Hospice service | 20% Coinsurance, after deductible | 40% Coinsurance, after deductible | --------none-------- |
| If your child needs dental or eye care | Eye exam | No Cost Share | No Cost Share | Coverage is limited to One Exam every calendar year.<br>Out-of-Network Providers: No Cost Share for the first $250, then covered at 40% Coinsurance. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Glasses | Not Covered | Not Covered | --------none-------- |
| | 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.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term 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.)

- Applied Behavioral Analysis (ABA) Therapy
- Bariatric surgery only for Morbid Obesity and must use an Anthem Blue Distinction Center (BDC or BDC+) or surgery is not covered; Precertification is required for both Inpatient and Outpatient services
- Gender Reassignment Surgery and related, medically necessary services
- Hearing aids (Benefit available to adults once every 3 calendar years and to children once every 2 calendar years regardless of reason for Hearing loss).
- Infertility treatment (Coverage for medical expenses is limited to a $24,000 family lifetime maximum; Prescription drug expenses are limited to a $7,500 family lifetime maximum)
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Routine eye care (Adult) (Coverage is limited to One Exam every calendar year. Covered as part of a Routine Physical; complete Eye Exams are Not Covered.)
- Routine foot care

## 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 1-855-593-8123. 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 BlueCross BlueShield
ATTN: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

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

## 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.

## It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

## 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:** $5,520
- **Patient pays:** $2,020

**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 | $170 |
| Total | $2,020 |

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $1,590
- **Patient pays:** $3,810

**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 | $0 |
| Coinsurance | $380 |
| Limits or exclusions | $2,930 |
| Total | $3,810 |

# 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.