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) 578-4443 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500**/person or **$1,000**/family for In-Network Providers. **$1,000**/person or **$2,000**/family for Non-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. Primary Care Specialist Visit Preventive Care for In-Network Providers. Tier 1 Tier 2 Tier 3 Tier 4 Prescription Drugs for In-Network and Non-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 out-of-pocket limit for this plan?	**$4,000**/person or **$8,000**/family for In-Network Providers. **$8,000**/person or **$16,000**/family for Non-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?	Premiums, balance-billing charges, health care this plan doesn't cover, and Non-Network Transplants.	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, Blue Access. See www.anthem.com or call (833) 578-4443 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-Network Provider (You will pay the least)	Non-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	$25/visit deductible does not apply	40% coinsurance	--------none--------
	Specialist visit	$25/visit deductible does not apply	40% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% coinsurance	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/ National Drug List	Tier 1 - Typically Generic	$10/prescription, deductible does not apply (retail) and $20/prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) with min $100 and Not covered (home delivery)	*See Prescription Drug section
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	$25/prescription, deductible does not apply (retail) and $65/prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) with min $100 and Not covered (home delivery)	
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	$40/prescription, deductible does not apply (retail) and $100/prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) with min $100 and Not covered (home delivery)	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
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--------
If you need immediate medical attention	Emergency room care	$200 visit deductible does not apply	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	Covered as In-Network	Non-emergency non-network Ambulance Services are limited to $50,000 per occurrence.
	Urgent care	$35/visit deductible does not apply	40% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	90 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $25/visit deductible does not apply Other Outpatient 20% coinsurance	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	20% coinsurance	40% coinsurance	--------none--------
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	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	90 visits/benefit period for Home Health
	Rehabilitation services	$25/visit deductible does not apply	40% coinsurance	*See Therapy Services section.
	Habilitation services	$25/visit deductible does not apply	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	90 days/benefit period for Inpatient physical medicine,

* 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-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				rehabilitation including day rehabilitation programs and skilled nursing services combined.
	Durable medical equipment	20% coinsurance	40% coinsurance	*See Durable Medical Equipment Section
	Hospice services	No charge	No charge	--------none--------
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	--------none--------
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Pediatric)
- Dental Check-up
- Eye exams for a child
- Glasses for a child
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Hearing Aids 1 Item(s)/ear every 36 months for children 18 years of age or under.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing 82 visits/benefit period. 164 visits/lifetime
- Spinal Manipulation 12 visits/benefit period

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 Insurance, 215 West Main Street, Frankfort, Kentucky 40601, (502) 564-3630, (800) 595-6053, TTY: (800) 648-6056, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, or contact Anthem at the number on the back of your ID card. 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.

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