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 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0.**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes, **$200** deductible for DME (external Prosthetics).	You must pay all of 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. **$100** Individual/**$200** Family Copayments.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	Premiums, Balance-billed charges and Health care this plan doesn't cover.	Not applicable because there's no **out–of–pocket limit** on your expenses.
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 **1-800-870-3122** 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.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **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 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** Copay/Visit	Not covered	——————none——————
	Specialist visit	**$20** Copay/Visit	Not covered	——————none——————
	Other practitioner office visit	**$20** Copay/Visit for Chiropractor	Not covered	Coverage is limited to 20 visits per member per plan year for Chiropractor. Acupuncture is Not Covered.
	Preventive care/screening/immunization	No Charges	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No Charges	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	No Charges	Not covered	——————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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/pharmacy information	Generic drugs	**$10** Copay/Prescription for Retail **$20** Copay/Prescription for Mail Order	Not covered	30 Day supply for Retail. 90 Day supply for Mail Order.
	Preferred brand drugs	**$30** Copay/Prescription for Retail **$60** Copay/Prescription for Mail Order	Not covered	30 Day supply for Retail. 90 Day supply for Mail Order.
	Non-preferred brand drugs	**$50** Copay/Prescription for Retail **$100** Copay/Prescription for Mail Order	Not covered	30 Day supply for Retail. 90 Day supply for Mail Order.
	Specialty drugs	**$50** Copay/Prescription for Retail **$100** Copay/Prescription for Mail Order	Not covered	30 Day supply for Retail. 90 Day supply for Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**$100** Copay/Surgery	Not Covered	——————none——————
	Physician/surgeon fees	No Charges	Not Covered	——————none——————
If you need immediate medical	Emergency room services	**$150** Copay/Visit	**$150** Copay/Visit	If admitted, the ER copay is waived.
	Emergency medical transportation	No Charges	Not Covered	——————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
attention	Urgent care	**$75** Copay/Visit	**$150** Copay/Visit	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	**$100** Copay/Admission	Not Covered	——————none——————
	Physician/surgeon fee	No Charges	Not Covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**$20** Copay/Visit	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	**$100** Copay/Admission	Not Covered	——————none——————
	Substance abuse disorder outpatient services	**$20** Copay/Visit	Not Covered	——————none——————
	Substance abuse disorder inpatient services	**$100** Copay/Admission	Not Covered	——————none——————
If you are pregnant	Prenatal and postnatal care	**$100** Copay/Admission	Not Covered	——————none——————
	Delivery and all inpatient services	**$100** Copay/Admission	Not Covered	——————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 need help recovering or have other special health needs	Home health care	No Charges	Not Covered	————————none————————
	Rehabilitation services	No Charges	Not Covered	Coverage is limited to 60 visits per member per plan year at any combination for Occupational, Physical or Speech Therapy.
	Habilitation services	No Charges	Not Covered	Coverage is limited to 60 visits per member per plan year at any combination for Occupational, Physical or Speech Therapy.
	Skilled nursing care	**$100** Copay/Admission	Not Covered	Coverage is limited to 100 days per member per plan year.
	Durable medical equipment	No Charges	Not Covered	————————none————————
	Hospice service	No Charges	Not Covered	————————none————————
If your child needs dental or eye care	Eye exam	No Charges	Not Covered	Coverage is limited to 1 exam per member per calendar year.
	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.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)**

- Chiropractor
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Routine eye care (Adult)

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 1-800-870-3122. You may also contact your state insurance department, the U.S. Department of Labor, Employee Calendars 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:

PO Box 533 North Haven CT 06473-0533.

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** $7,250
- **Patient pays** $290

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	$0
Copays	$140
Coinsurance	$0
Limits or exclusions	$150
Total	**$290**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,720
- **Patient pays** $680

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	$0
Copays	$600
Coinsurance	$0
Limits or exclusions	$80
Total	**$680**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: [1-800-870-3122].

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 Calendars 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.

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 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** for In Network. **$100** Member/**$300** Family per calendar year for Out of Network providers.	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, **$200** deductible for DME (external Prosthetics).	You must pay all of 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, **$100** Individual/ **$200** Family In Network Copayments. **$500** Member/**$1,500** Family per calendar year for Out of Network providers.	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 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 **1-800-870-3122** 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.

Questions: Call 1-800-870-3122 or visit us at www.anthem.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.anthem.com or call 1-800-870-3122 to request a copy.

Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. 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** Copay/Visit	**20%** Coinsurance	——————None——————
	Specialist visit	**$20** Copay/Visit	**20%** Coinsurance	——————None——————
	Other practitioner office visit	**$20** Copay/Visit for Chiropractor	**20%** Coinsurance for Chiropractor	Coverage is limited to 20 visits per plan year for Chiropractor. Acupuncture is Not Covered.
	Preventive care/screening/immunization	No Charges	**20%** Coinsurance	——————None——————
If you have a test	Diagnostic test (x-ray, blood work)	No Charges	**20%** Coinsurance	——————None——————
	Imaging (CT/PET scans, MRIs)	No Charges	**20%** Coinsurance	——————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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/pharmacy information.	Generic drugs	**$10** Copay/Prescription for Retail Pharmacy **$20** Copay/Prescription for Mail Order	**$10** Copay/Prescription for Retail Pharmacy **$20** Copay/Prescription for Mail Order	30-day supply for Retail Pharmacy. 90-day supply for Mail Order.
	Preferred brand drugs	**$30** Copay/Prescription for Retail Pharmacy **$60** Copay/Prescription for Mail Order	**$30** Copay/Prescription for Retail Pharmacy **$60** Copay/Prescription for Mail Order	30-day supply for Retail Pharmacy. 90-day supply for Mail Order.
	Non-preferred brand drugs	**$50** Copay/Prescription for Retail Pharmacy **$100** Copay/Prescription for Mail Order	**$50** Copay/Prescription for Retail Pharmacy **$100** Copay/Prescription for Mail Order	30-day supply for Retail Pharmacy. 90-day supply for Mail Order.
	Specialty drugs	**$50** Copay/Prescription for Retail Pharmacy **$100** Copay/Prescription for Mail Order	**$50** Copay/Prescription for Retail Pharmacy **$100** Copay/Prescription for Mail Order	30-day supply for Retail Pharmacy. 90-day supply for Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**$100** Copay/Surgery	**20%** Coinsurance	——————None——————
	Physician/surgeon fees	No Charges	**20%** Coinsurance	——————None——————
If you need immediate medical	Emergency room services	**$150** Copay/Visit	**$150** Copay/Visit	If admitted, the ER copay is waived.
	Emergency medical transportation	No Charges	No Charges	——————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
attention	Urgent care	**$75** Copay/Visit	**$150** Copay/Visit	——————None——————
If you have a hospital stay	Facility fee (e.g., hospital room)	**$100** Copay/Admission	**20%** Coinsurance	——————None——————
	Physician/surgeon fee	No Charges	**20%** Coinsurance	——————None——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**$20** Copay/Visit	**20%** Coinsurance	——————None——————
	Mental/Behavioral health inpatient services	**$100** Copay/Admission	**20%** Coinsurance	——————None——————
	Substance Abuse disorder outpatient services	**$20** Copay/Visit	**20%** Coinsurance	——————None——————
	Substance Abuse disorder inpatient services	**$100** Copay/Admission	**20%** Coinsurance	——————None——————
If you are pregnant	Prenatal and postnatal care	**$100** Copay/Admission	**20%** Coinsurance	——————None——————
	Delivery and all inpatient services	**$100** Copay/Admission	**20%** Coinsurance	——————None——————
If you need help recovering or have other special health needs	Home health care	No Charges	**20%** Coinsurance	——————None——————
	Rehabilitation services	No Charges	**20%** Coinsurance	Unlimited
	Habilitation services	No Charges	**20%** Coinsurance	——————None——————
	Skilled nursing care	**$100** Copay/Admission	**20%** Coinsurance	Coverage is limited to 100 combined days in a skilled nursing facility and rehabilitation facility per member per calendar year.
	Durable medical equipment	No Charges	**20%** Coinsurance	——————None——————
	Hospice service	No Charges	**20%** Coinsurance	——————None——————
If your child needs dental or eye care	Eye exam	No Charges	**20%** Coinsurance	One exam per member per calendar year.
	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.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- 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
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage:

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For more information on your rights to continue coverage, contact the plan at 1-800-870-3122. 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.

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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。

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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** $7,270
- **Patient pays** $270

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	$0
Copays	$120
Coinsurance	$0
Limits or exclusions	$150
Total	**$270**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,720
- **Patient pays** $680

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	$0
Copays	$600
Coinsurance	$0
Limits or exclusions	$80
Total	**$680**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: [1-800-870-3122].

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.

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 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0.**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes, **$200** deductible for DME (external Prosthetics).	You must pay all of 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. **$250** Individual/**$500** Family Copayments.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	Premiums, Balance-billed charges and Health care this plan doesn't cover.	Not applicable because there's no **out–of–pocket limit** on your expenses.
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 **1-800-870-3122** 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.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **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 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** Copay/Visit	Not covered	——————none——————
	Specialist visit	**$20** Copay/Visit	Not covered	——————none——————
	Other practitioner office visit	**$20** Copay/Visit for Chiropractor	Not covered	Coverage is limited to 20 visits per plan year for Chiropractor. Acupuncture is Not Covered.
	Preventive care/screening/immunization	No Charges	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No Charges	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	No Charges	Not covered	——————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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/pharmacy information	Generic drugs	**$10** Copay/Prescription for Retail **$20** Copay/Prescription for Mail Order	Not covered	30 Day supply for Retail. 90 Day supply for Mail Order.
	Preferred brand drugs	**$30** Copay/Prescription for Retail **$60** Copay/Prescription for Mail Order	Not covered	30 Day supply for Retail. 90 Day supply for Mail Order.
	Non-preferred brand drugs	**$50** Copay/Prescription for Retail **$100** Copay/Prescription for Mail Order	Not covered	30 Day supply for Retail. 90 Day supply for Mail Order.
	Specialty drugs	**$50** Copay/Prescription for Retail **$100** Copay/Prescription for Mail Order	Not covered	30 Day supply for Retail. 90 Day supply for Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**$250** Copay/Surgery	Not Covered	——————none——————
	Physician/surgeon fees	No Charges	Not Covered	——————none——————
If you need immediate medical	Emergency room services	**$150** Copay/Visit	**$150** Copay/Visit	If admitted, the ER copay is waived.
	Emergency medical transportation	No Charges	Not Covered	——————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
attention	Urgent care	**$75** Copay/Visit	**$150** Copay/Visit	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	**$250** Copay/Admission	Not Covered	——————none——————
	Physician/surgeon fee	No Charges	Not Covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**$20** Copay/Visit	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	**$250** Copay/Admission	Not Covered	——————none——————
	Substance abuse disorder outpatient services	**$20** Copay/Visit	Not Covered	——————none——————
	Substance abuse disorder inpatient services	**$250** Copay/Admission	Not Covered	——————none——————
If you are pregnant	Prenatal and postnatal care	**$250** Copay/Admission	Not Covered	——————none——————
	Delivery and all inpatient services	**$250** Copay/Admission	Not Covered	——————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 need help recovering or have other special health needs	Home health care	No Charges	Not Covered	————————none————————
	Rehabilitation services	No Charges	Not Covered	Coverage is limited to 60 visits per calendar year at any combination for Occupational, Physical or Speech Therapy per plan year.
	Habilitation services	No Charges	Not Covered	Coverage is limited to 60 visits per calendar year at any combination for Occupational, Physical or Speech Therapy per plan year.
	Skilled nursing care	**$250** Copay/Admission	Not Covered	Coverage is limited to 100 days per calendar year.
	Durable medical equipment	No Charges	Not Covered	————————none————————
	Hospice service	No Charges	Not Covered	————————none————————
If your child needs dental or eye care	Eye exam	No Charges	Not Covered	Coverage is limited to one exam per member per calendar year.
	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Hearing aids
- Long-term care
- Private-duty nursing
- 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.)

- Chiropractor
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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 1-800-870-3122. You may also contact your state insurance department, the U.S. Department of Labor, Employee Calendars 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:

PO Box 533 North Haven CT 06473-0533

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** $7,100
- **Patient pays** $440

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	$0
Copays	$290
Coinsurance	$0
Limits or exclusions	$150
Total	**$440**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,720
- **Patient pays** $680

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	$0
Copays	$600
Coinsurance	$0
Limits or exclusions	$80
Total	**$680**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: [1-800-870-3122].

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 Calendars 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.

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 1-800-870-3122.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** for In-network. **$100** Individual/**$300** Family for Out of Network providers.	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, **$200** deductible for DME (external Prosthetics).	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, **$250** Individual/**500** Family for In Network copayments. **$500** Individual/**$1,500** Family for Out of Network providers	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 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 **1-800-870-3122** 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	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan

plan doesn't cover?		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** Copay/Visit	**20%** Coinsurance	——————none——————
	Specialist visit	**$20** Copay/Visit	**20%** Coinsurance	——————none——————
	Other practitioner office visit	**$20** Copay/Visit for Chiropractor	**20%** Coinsurance for Chiropractor	Coverage is limited to 20 visits per member per plan year for Chiropractor. Acupuncture is Not Covered.
	Preventive care/screening/immunization	No Charges	**20%** Coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No Charges	**20%** Coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	No Charges	**20%** Coinsurance	——————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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/pharmacy information	Generic drugs	**$10** Copay/Prescription for Retail. **$20** Copay/Prescription for Mail Order.	**$10** Copay/Prescription for Retail. **$20** Copay/Prescription for Mail Order.	30 Day supply for Retail 90 Day Supply for Mail Order
	Preferred brand drugs	**$30** Copay/Prescription for Retail. **$60** Copay/Prescription for Mail Order.	**$30** Copay/Prescription for Retail. **$60** Copay/Prescription for Mail Order.	30 Day supply for Retail 90 Day Supply for Mail Order
	Non-preferred brand drugs	**$50** Copay/Prescription for Retail. **$100** Copay/Prescription for Mail Order.	**$50** Copay/Prescription for Retail. **$100** Copay/Prescription for Mail Order.	30 Day supply for Retail 90 Day Supply for Mail Order
	Specialty drugs	**$50** Copay/Prescription for Retail. **$100** Copay/Prescription for Mail Order.	**$50** Copay/Prescription for Retail. **$100** Copay/Prescription for Mail Order.	30 Day supply for Retail 90 Day Supply for Mail Order
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**$250** Copay/Visit	**20%** Coinsurance	——————none——————
	Physician/surgeon fees	No Charges	No Charges	——————none——————
If you need immediate medical attention	Emergency room services	**$150** Copay/Visit	**$150** Copay/Visit	If admitted, the ER copay is waived.
	Emergency medical transportation	No Charges	No Charges	——————none——————
	Urgent care	**$75** Copay/Visit	**$150** Copay/Visit	——————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 a hospital stay	Facility fee (e.g., hospital room)	**$250** Copay/Admission	**20%** Coinsurance	——————none——————
	Physician/surgeon fee	No Charges	**20%** Coinsurance	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**$20** Copay/Visit	**20%** Coinsurance	——————none——————
	Mental/Behavioral health inpatient services	**$250** Copay/Admission	**20%** Coinsurance	——————none——————
	Substance abuse disorder outpatient services	**$20** Copay/Visit	**20%** Coinsurance	——————none——————
	Substance abuse disorder inpatient services	**$250** Copay/Admission	**20%** Coinsurance	——————none——————
If you are pregnant	Prenatal and postnatal care	**$250** Copay/Visit	**20%** Coinsurance	——————none——————
	Delivery and all inpatient services	**$250** Copay/Admission	**20%** Coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	No Charges	**20%** Coinsurance	——————none——————
	Rehabilitation services	No Charges	**20%** Coinsurance	Unlimited
	Habilitation services	No Charges	**20%** Coinsurance	——————none——————
	Skilled nursing care	**$250** Copay/Admission	**20%** Coinsurance	Coverage is limited to 100 combined days in a skilled nursing facility and rehabilitation facility per member per calendar year.
	Durable medical equipment	No Charges	**20%** Coinsurance	——————none——————
	Hospice service	No Charges	**20%** Coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	$20 Copay	Not Covered	——————none——————
	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.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Hearing aids
- Long-term care
- Private-duty nursing
- 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.)**

- Chiropractor
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Non-emergency care when traveling outside the U.S.

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For more information on your rights to continue coverage, contact the plan at 1-800-870-3122. You may also contact your state insurance department, the U.S. Department of Labor, Employee Calendars 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.

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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。

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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.

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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** $7,100
- **Patient pays** $440

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	$0
Copays	$290
Coinsurance	$0
Limits or exclusions	$150
Total	**$440**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,720
- **Patient pays** $680

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	$0
Copays	$600
Coinsurance	$0
Limits or exclusions	$80
Total	**$680**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: [1-800-870-3122].

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 Calendars 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.

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 1-888-224-4896.

Health Savings Account Contributions: **$3,250** Individual/**$6,450** Family.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** Individual/**$4,000** Family for Network and Out of Network providers.	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, **$2,000** Individual/**$4,000** Family for Network providers. **$4,000** Individual/**$8,000** Family for Out of Network providers.	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 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 **1-888-224-4896** for a list of 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 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 Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a 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	No Charges	**30%** Coinsurance	——————None——————
	Specialist visit	No Charges	**30%** Coinsurance	——————None——————
	Other practitioner office visit	No Charges for Chiropractor	**30%** Coinsurance for Chiropractor	Coverage is limited to 12 visits per member per contract year for Chiropractor. Acupuncture is Not Covered.
	Preventive care/screening/immunization	No Charges	**30%** Coinsurance	——————None——————
If you have a test	Diagnostic test (x-ray, blood work)	No Charges	**30%** Coinsurance	——————None——————
	Imaging (CT/PET scans, MRIs)	No Charges	**30%** Coinsurance	——————None——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Out of Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/pharmacy information.	Generic drugs	No Charges	**30%** Coinsurance	——————None——————
	Preferred brand drugs	No Charges	**30%** Coinsurance	——————None——————
	Non-preferred brand drugs	No Charges	**30%** Coinsurance	——————None——————
	Specialty drugs	No Charges	**30%** Coinsurance	——————None——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charges	**30%** Coinsurance	——————None——————
	Physician/surgeon fees	No Charges	**30%** Coinsurance	——————None——————
If you need immediate medical attention	Emergency room services	No Charges	No Charges	——————None——————
	Emergency medical transportation	No Charges	**30%** Coinsurance	——————None——————
	Urgent care	No Charges	**30%** Coinsurance	——————None——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charges	**30%** Coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fee	No Charges	**30%** Coinsurance	——————None——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Out of Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charges	**30%** Coinsurance	————————None————————
	Mental/Behavioral health inpatient services	No Charges	**30%** Coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Substance Abuse disorder outpatient services	No Charges	**30%** Coinsurance	————————None————————
	Substance Abuse disorder inpatient services	No Charges	**30%** Coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you are pregnant	Prenatal and postnatal care	No Charges	**30%** Coinsurance	————————None————————
	Delivery and all inpatient services	No Charges	**30%** Coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Out of Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charges	**30%** Coinsurance	Coverage is limited to 100 visits per member per calendar year.
	Rehabilitation services	No Charges	**30%** Coinsurance	Coverage is limited to 60 visits per member per contract year combined for Occupational, Physical and Speech therapy.
	Habilitation services	No Charges	**30%** Coinsurance	Coverage is limited to 60 visits per member per contract year combined for Occupational, Physical and Speech therapy.
	Skilled nursing care	No Charges	**30%** Coinsurance	Coverage is limited to 100 days per member per calendar year. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Durable medical equipment	No Charges	**30%** Coinsurance	——————None——————
	Hospice service	No Charges	**30%** Coinsurance	——————None——————
If your child needs dental or eye care	Eye exam	No Charges	**30%** Coinsurance	Coverage is limited to one per member per calendar year.
	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- 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
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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 1-888-224-4896. 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:

PO Box 533 North Haven CT 06473-0533.

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** $5,390
- **Patient pays** $2,150

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

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,320
- **Patient pays** $2,080

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	$2,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,080**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-888-224-4896.

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.

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 1-800-870-3122.

Health Savings Account Contributions: **$3,250** Individual/**$6,450** Family.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,000** Individual/**$4,000** Family for Network and Out of Network providers.	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. **$2,000** Individual/**$4,000** Family for Network providers. **$4,000** Individual/**$8,000** Family for Out of Network providers.	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 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 **1-800-870-3122** for a list of 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	No. You don't need a referral to	You can see the **specialist** you choose without permission from this plan.

see a specialist?	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 Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a 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	No Charges	**30%** Coinsurance	——————None——————
	Specialist visit	No Charges	**30%** Coinsurance	——————None——————
	Other practitioner office visit	No Charges for Chiropractor	**30%** Coinsurance for Chiropractor	Coverage is limited to 12 visits per member per contract year for Chiropractor. Acupuncture is Not Covered.
	Preventive care/screening/immunization	No Charges	**30%** Coinsurance	——————None——————
If you have a test	Diagnostic test (x-ray, blood work)	No Charges	**30%** Coinsurance	——————None——————
	Imaging (CT/PET scans, MRIs)	No Charges	**30%** Coinsurance	——————None——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Out of Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/pharmacy information.	Generic drugs	No Charges	**30%** Coinsurance	——————None——————
	Preferred brand drugs	No Charges	**30%** Coinsurance	——————None——————
	Non-preferred brand drugs	No Charges	**30%** Coinsurance	——————None——————
	Specialty drugs	No Charges	**30%** Coinsurance	——————None——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charges	**30%** Coinsurance	——————None——————
	Physician/surgeon fees	No Charges	**30%** Coinsurance	——————None——————
If you need immediate medical attention	Emergency room services	No Charges	No Charges	——————None——————
	Emergency medical transportation	No Charges	**30%** Coinsurance	——————None——————
	Urgent care	No Charges	**30%** Coinsurance	——————None——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charges	**30%** Coinsurance	Failure to obtain pre-authorization may result in non coverage or reduced benefits.
	Physician/surgeon fee	No Charges	**30%** Coinsurance	——————None——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Out of Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charges	**30%** Coinsurance	————————None————————
	Mental/Behavioral health inpatient services	No Charges	**30%** Coinsurance	Failure to obtain pre-authorization may result in non coverage or reduced benefits.
	Substance Abuse disorder outpatient services	No Charges	**30%** Coinsurance	————————None————————
	Substance Abuse disorder inpatient services	No Charges	**30%** Coinsurance	Failure to obtain pre-authorization may result in non coverage or reduced benefits.
If you are pregnant	Prenatal and postnatal care	No Charges	**30%** Coinsurance	————————None————————
	Delivery and all inpatient services	No Charges	**30%** Coinsurance	Failure to obtain pre-authorization may result in non coverage or reduced benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Out of Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charges	**30%** Coinsurance	Coverage is limited to 100 visits per member per calendar year.
	Rehabilitation services	No Charges	**30%** Coinsurance	Coverage is limited to 60 visits per member per contract year combined for Occupational, Physical and Speech therapy.
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	Durable medical equipment	No Charges	**30%** Coinsurance	——————None——————
	Hospice service	No Charges	**30%** Coinsurance	——————None——————
If your child needs dental or eye care	Eye exam	No Charges	**30%** Coinsurance	Coverage is limited to one per member per calendar year.
	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- 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
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
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Your Rights to Continue Coverage:

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For more information on your rights to continue coverage, contact the plan at 1-800-870-3122. 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.

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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.

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See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,390
- **Patient pays** $2,150

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

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,320
- **Patient pays** $2,080

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	$2,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,080**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-870-3122.

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.

Anthem Blue Cross and Blue Shield
City of Manchester Out of Area Early Retirees (SIPBN839PY)

Coverage Period: 07/01/2013 – 06/30/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family | **Plan Type:** PPO

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 1-800-852-6592.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** for In Network. **$100** Member/**$300** Family per calendar year for Out of Network providers.	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, **$200** deductible for DME (external Prosthetics).	You must pay all of 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, **$100** Individual/**$200** Family In Network. **$500** Member/**$1,500** Family per calendar year for Out of Network providers.	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 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 **1-800-852-6592** 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 5. 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** Copay/Visit	**20%** Coinsurance	——————None——————
	Specialist visit	**$20** Copay/Visit	**20%** Coinsurance	——————None——————
	Other practitioner office visit	**$20** Copay/Visit for Chiropractor	**20%** Coinsurance for Chiropractor	Coverage is limited to 20 visits per member per plan year for Chiropractor. Acupuncture is Not Covered.
	Preventive care/screening/immunization	No Charges	**20%** Coinsurance	——————None——————
If you have a test	Diagnostic test (x-ray, blood work)	No Charges	**20%** Coinsurance	——————None——————
	Imaging (CT/PET scans, MRIs)	No Charges	**20%** Coinsurance	——————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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com/pharmacy information.	Generic drugs	**$10** Copay/Prescription for Retail Pharmacy **$20** Copay/Prescription for Mail Order	**$10** Copay/Prescription for Retail Pharmacy **$20** Copay/Prescription for Mail Order	30-day supply for Retail Pharmacy. 90-day supply for Mail Order.
	Preferred brand drugs	**$30** Copay/Prescription for Retail Pharmacy **$60** Copay/Prescription for Mail Order	**$30** Copay/Prescription for Retail Pharmacy **$60** Copay/Prescription for Mail Order	30-day supply for Retail Pharmacy. 90-day supply for Mail Order.
	Non-preferred brand drugs	**$50** Copay/Prescription for Retail Pharmacy **$100** Copay/Prescription for Mail Order	**$50** Copay/Prescription for Retail Pharmacy **$100** Copay/Prescription for Mail Order	30-day supply for Retail Pharmacy. 90-day supply for Mail Order.
	Specialty drugs	**$50** Copay/Prescription for Retail Pharmacy **$100** Copay/Prescription for Mail Order	**$50** Copay/Prescription for Retail Pharmacy **$100** Copay/Prescription for Mail Order	30-day supply for Retail Pharmacy. 90-day supply for Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**$100** Copay/Surgery	**20%** Coinsurance	——————None——————
	Physician/surgeon fees	No Charges	**20%** Coinsurance	——————None——————
If you need immediate medical	Emergency room services	**$150** Copay/Visit	**$150** Copay/Visit	If admitted, the ER copay is waived.
	Emergency medical transportation	No Charges	No Charges	——————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
attention	Urgent care	**$75** Copay/Visit	**$150** Copay/Visit	——————None——————
If you have a hospital stay	Facility fee (e.g., hospital room)	**$100** Copay/Admission	**20%** Coinsurance	——————None——————
	Physician/surgeon fee	No Charges	**20%** Coinsurance	——————None——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**$20** Copay/Visit	**20%** Coinsurance	——————None——————
	Mental/Behavioral health inpatient services	**$100** Copay/Admission	**20%** Coinsurance	——————None——————
	Substance Abuse disorder outpatient services	**$20** Copay/Visit	**20%** Coinsurance	——————None——————
	Substance Abuse disorder inpatient services	**$100** Copay/Admission	**20%** Coinsurance	——————None——————
If you are pregnant	Prenatal and postnatal care	**$100** Copay/Admission	**20%** Coinsurance	——————None——————
	Delivery and all inpatient services	**$100** Copay/Admission	**20%** Coinsurance	——————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 need help recovering or have other special health needs	Home health care	No Charges	**20%** Coinsurance	————————None————————
	Rehabilitation services	No Charges	**20%** Coinsurance	Coverage is limited to 60 combined visits per member per plan year for Occupational, Physical and Speech therapy.
	Habilitation services	No Charges	**20%** Coinsurance	Coverage is limited to 60 combined visits per member per plan year for Occupational, Physical and Speech therapy.
	Skilled nursing care	**$100** Copay/Admission	**20%** Coinsurance	Coverage is limited to 100 combined days in a skilled nursing facility and rehabilitation facility per member per calendar year.
	Durable medical equipment	No Charges	**20%** Coinsurance	————————None————————
	Hospice service	No Charges	**20%** Coinsurance	————————None————————
If your child needs dental or eye care	Eye exam	No Charges	**20%** Coinsurance	One exam per member per calendar year.
	Glasses	No Charges	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.)		
• Acupuncture	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Hearing aids	• Weight loss programs
• Dental care (Adult)	• Long-term care	• Private-duty nursing

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	• Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide	• Non-emergency care when traveling outside the U.S. • Routine eye care (Adult)

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 1-800-852-6592. 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:

PO Box 533, North Haven CT 06473-0533.

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** $7,270
- **Patient pays** $270

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	$0
Copays	$120
Coinsurance	$0
Limits or exclusions	$150
Total	**$270**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,720
- **Patient pays** $680

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	$0
Copays	$600
Coinsurance	$0
Limits or exclusions	$80
Total	**$680**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: [1-800-852-6592].

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.
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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?

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✓ **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?

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