



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-451-1527.

| Important Questions | Answers | Why this Matters: |
|---|--|---|
| What is the overall <u>deductible</u> ? | \$200 Individual/ \$400 Family for In Network providers. \$300 Individual/ \$600 Family for Out of Network providers. | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| Is there an <u>out-of-pocket limit</u> on my expenses? | Yes. \$3,500 Individual/ \$7,000 Family for In Network providers. \$3,750 Individual/ \$7,500 Family for Out of Network providers. | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ? | Your share of the cost of routine vision care, Premiums, Balance-billed charges and Health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| 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 <i>specific</i> covered services, such as office visits. |
| Does this plan use a <u>network of providers</u> ? | Yes. See www.anthem.com or call 1-800-451-1527 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. |

Questions: Call 1-800-451-1527 or visit us at www.anthem.com

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Montgomery County Anthem KeyCare 200 Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2016 – 09/30/2017

Coverage for: Individual/Family | Plan Type: PPO

| | | |
|---|--|---|
| 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 8. 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 | 30% Coinsurance | —————none————— |
| | Specialist visit | \$40 Copay/Visit | 30% Coinsurance | —————none————— |
| | Other practitioner office visit | \$20/visit (PCP) or \$40/visit (specialist) | 30% Coinsurance for Chiropractor | Coverage is limited to 30 visits for Chiropractor combined In Network and Out of Network. There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation. Acupuncture is not covered. |

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Montgomery County Anthem KeyCare 200 Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2016 – 09/30/2017

Coverage for: Individual/Family | Plan Type: PPO

| 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 |
|--|--|--|--|--|
| | Preventive care/screening/immunization | No Charges | 30% Coinsurance | —————none————— |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% Coinsurance | 30% Coinsurance | —————none————— |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance | 30% Coinsurance | —————none————— |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.anthem.com | Generic drugs (Tier 1) | \$10 copay/ prescription for Retail \$10 copay / prescription for Mail order* | \$10 copay/ prescription for Retail \$10 copay / prescription for Mail order* | Retail pharmacy drugs are limited to a 30-day supply. Mail order drugs are limited to a 90-day day supply. If you visit an out-of-network pharmacy, you will pay the full cost of your prescription at the pharmacy then file a claim for reimbursement. Reimbursement will be based on what a participating pharmacy would receive had the prescription been filled at a participating pharmacy. *You may also be subject to any costs above the allowed amount. |
| | Preferred brand drugs (Tier 2) | \$30 copay/ prescription for Retail \$60 copay/ prescription for Mail order* | \$30 copay/ prescription for Retail \$60 copay/ prescription for Mail order* | |
| | Non-preferred brand drugs (Tier 3) | \$50 copay/ prescription for Retail \$150 copay/ prescription for Mail order* | \$50 copay/ prescription for Retail \$150 copay/ prescription for Mail order* | Your plan uses a preferred drug list (formulary) which identifies the status of covered drugs. Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements. If the necessary preauthorization is not obtained, the drug may not be covered. |

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Montgomery County Anthem KeyCare 200 Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2016 – 09/30/2017

Coverage for: Individual/Family | Plan Type: PPO

| 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 outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$100 Copay/Visit plus 20% Coinsurance | 30% Coinsurance | —————none————— |
| | Physician/surgeon fees | 20% Coinsurance | 30% Coinsurance | —————none————— |
| If you need immediate medical attention | Emergency room services | \$100 Copay/Visit plus 20% Coinsurance | 30% Coinsurance | —————none————— |
| | Emergency medical transportation | 20% Coinsurance | 30% Coinsurance | —————none————— |
| | Urgent care | \$20/visit (PCP) or \$40/visit (specialist) | 30% Coinsurance | There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$300 Copay/Admission plus 20% Coinsurance | 30% Coinsurance | —————none————— |
| | Physician/surgeon fee | 20% Coinsurance | 30% Coinsurance | —————none————— |

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2016 – 09/30/2017

Coverage for: Individual/Family | Plan Type: PPO

| Common Medical Event | Services You May Need | Your Cost If You Use an In Network Provider | Your Cost If You Use an Out of Network Provider | Limitations & Exceptions |
|---|--|---|---|---|
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | No Charges | 30% Coinsurance | —————none————— |
| | Mental/Behavioral health inpatient services | \$300 Copay/Admission plus 20% Coinsurance | 30% Coinsurance | —————none————— |
| | Substance Abuse disorder outpatient services | No Charges | 30% Coinsurance | —————none————— |
| | Substance Abuse disorder inpatient services | \$300 Copay/Admission plus 20% Coinsurance | 30% Coinsurance | —————none————— |
| If you are pregnant | Prenatal and postnatal care | \$20/visit (PCP) or \$40/visit (specialist) | 30% Coinsurance | There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation. |
| | Delivery and all inpatient services | \$300 Copay/Admission plus 20% Coinsurance | 30% Coinsurance | —————none————— |

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Coverage Period: 10/01/2016 – 09/30/2017

Coverage for: Individual/Family | Plan Type: PPO

| Common Medical Event | Services You May Need | Your Cost If You Use an In Network Provider | Your Cost If You Use an Out of Network Provider | Limitations & Exceptions |
|---|---------------------------|---|---|--|
| If you need help recovering or have other special health needs | Home health care | 20% Coinsurance | 30% Coinsurance | Coverage is limited to 100 visits combined In Network and Out of Network. |
| | Rehabilitation services | 20% Coinsurance | 30% Coinsurance | Coverage is limited to 30 combined visits for Occupational and Physical therapy combined In Network and Out of Network. Coverage is limited to 30 visits for Speech therapy combined In Network and Out of Network. |
| | Habilitation services | 20% Coinsurance | 30% Coinsurance | Coverage is limited to 30 combined visits for Occupational and Physical therapy combined In Network and Out of Network. Coverage is limited to 30 visits for Speech therapy combined In Network and Out of Network. |
| | Skilled nursing care | \$300 Copay/Admission plus 20% Coinsurance | 30% Coinsurance | Coverage is limited to 100 days for each admission combined In Network and Out of Network. |
| | Durable medical equipment | 20% Coinsurance | 30% Coinsurance | —————none————— |
| | Hospice service | No Charges | 30% Coinsurance | —————none————— |
| If your child needs dental or eye care | Eye exam | \$15/visit | Balance-billed charges after \$30 benefit maximum | Out-of-Network benefit not subject to deductible. |
| | Glasses | Not Covered | Not Covered | —————none————— |

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2016 – 09/30/2017

Coverage for: Individual/Family | Plan Type: PPO

| 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 |
|----------------------|-----------------------|---|---|--------------------------|
| | Dental check-up | Not Covered | Not Covered | —————none————— |

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

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

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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 1-800-451-1527. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

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

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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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 adoolwoł íínízínigo t'áá diné k'éjíggo, t'áá shoodí ba na'aln'íhí ya sidáhí bich'í naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aalágí bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'núłígú bi'kéhgo bich'í hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call 1-800-451-1527 or visit us at www.anthem.com

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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 \$6,730
- Patient pays \$810

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 | \$200 |
| Copays | \$340 |
| Coinsurance | \$120 |
| Limits or exclusions | \$150 |
| Total | \$810 |

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

- Amount owed to providers: \$5,400
- Plan pays \$4,280
- Patient pays \$1,120

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 | \$200 |
| Copays | \$600 |
| Coinsurance | \$240 |
| Limits or exclusions | \$80 |
| Total | \$1,120 |

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: www.anthem.com or 1-800-451-1527.

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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.

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Montgomery County Anthem KeyCare 1,000 Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2016 – 09/30/2017

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 1-800-451-1527.

| Important Questions | Answers | Why this Matters: |
|---|--|---|
| What is the overall <u>deductible</u> ? | \$1,000 Individual/ \$2,000 Family for In Network providers. \$1,500 Individual/ \$3,000 Family for Out of Network providers. | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | Yes. \$150 Individual/ \$300 Family for Tier 2 and Tier 3 prescription drugs. | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services. |
| Is there an <u>out-of-pocket limit</u> on my expenses? | Yes. \$5,000 Individual/ \$10,000 Family for In Network providers. \$5,250 Individual/ \$10,500 Family for Out of Network providers. | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ? | Your share of the cost of routine vision care, Premiums, Balance-billed charges and Health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| 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 <i>specific</i> covered services, such as office visits. |
| Does this plan use a | Yes. See www.anthem.com or | If you use an in-network doctor or other health care provider, this plan will pay some or all |

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Coverage Period: 10/01/2016 – 09/30/2017

Coverage for: Individual/Family | Plan Type: PPO

| | | |
|---|---|---|
| network of providers? | call 1-800-451-1527 for a list of In Network providers. | 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 <u>specialist</u>? | No. You don't need a referral to see a specialist. | You can see the <u>specialist</u> you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about <u>excluded services</u> . |



- **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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Specialist visit | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Other practitioner office visit | 20% Coinsurance for Chiropractor | 40% Coinsurance for Chiropractor | Coverage is limited to 30 visits for Chiropractor combined In Network and Out of Network. Acupuncture is not covered. |
| | Preventive care/screening/immunization | No Charge | 40% Coinsurance | —————none————— |

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Coverage for: Individual/Family | Plan Type: PPO

| 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 test | Diagnostic test (x-ray, blood work) | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance | 40% Coinsurance | —————none————— |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.anthem.com | Generic drugs (Tier 1) | \$15 copay/ prescription for Retail \$15 copay / prescription for Mail order* | \$10 copay/ prescription for Retail \$10 copay / prescription for Mail order* | Retail pharmacy drugs are limited to a 30-day supply. Mail order drugs are limited to a 90-day day supply. If you visit an out-of-network pharmacy, you will pay the full cost of your prescription at the pharmacy then file a claim for reimbursement. Reimbursement will be based on what a participating pharmacy would receive had the prescription been filled at a participating pharmacy. *You may also be subject to any costs above the allowed amount. |
| | Preferred brand drugs (Tier 2) | \$30 copay/ prescription for Retail Pharmacy \$60 copay/ prescription for Mail order | \$30 copay/ prescription for Retail \$60 copay/ prescription for Mail order | |
| | Non-preferred brand drugs (Tier 3) | \$60 copay/ prescription for Retail Pharmacy \$180 copay/ prescription for Mail order | \$60 copay/ prescription for Retail \$180 copay/ prescription for Mail order* | Your plan uses a preferred drug list (formulary) which identifies the status of covered drugs. Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements. If the necessary preauthorization is not obtained, the drug may not be covered. |

Questions: Call 1-800-451-1527 or visit us at www.anthem.com

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Montgomery County Anthem KeyCare 1,000 Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2016 – 09/30/2017

Coverage for: Individual/Family | Plan Type: PPO

| 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 outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | —————none————— |
| If you need immediate medical attention | Emergency room services | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Emergency medical transportation | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Urgent care | 20% Coinsurance | 40% Coinsurance | —————none————— |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Physician/surgeon fee | 20% Coinsurance | 40% Coinsurance | —————none————— |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Mental/Behavioral health inpatient services | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Substance Abuse disorder outpatient services | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Substance Abuse disorder inpatient services | 20% Coinsurance | 40% Coinsurance | —————none————— |
| If you are pregnant | Prenatal and postnatal care | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Delivery and all inpatient services | 20% Coinsurance | 40% Coinsurance | —————none————— |

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Montgomery County Anthem KeyCare 1,000 Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2016 – 09/30/2017

Coverage for: Individual/Family | Plan Type: PPO

| Common Medical Event | Services You May Need | Your Cost If You Use an In Network Provider | Your Cost If You Use an Out of Network Provider | Limitations & Exceptions |
|---|---|---|---|--|
| If you need help recovering or have other special health needs | Home health care | 20% Coinsurance | 40% Coinsurance | Coverage is limited to 100 visits combined In Network and Out of Network. |
| | Rehabilitation services | 20% Coinsurance | 40% Coinsurance | Coverage is limited to 30 combined visits for Occupational and Physical therapy combined In Network and Out of Network. Coverage is limited to 30 visits for Speech therapy combined In Network and Out of Network. |
| | Habilitation services | 20% Coinsurance | 40% Coinsurance | Coverage is limited to 30 combined visits for Occupational and Physical therapy combined In Network and Out of Network. Coverage is limited to 30 visits for Speech therapy combined In Network and Out of Network. |
| | Skilled nursing care | 20% Coinsurance | 40% Coinsurance | Coverage is limited to 100 days for each admission combined In Network and Out of Network. |
| | Durable medical equipment | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Hospice service | No Charges | 40% Coinsurance | —————none————— |
| | If your child needs dental or eye care | Eye exam | \$15 Copay/Visit | Balance-billed charges after \$30 benefit maximum |
| Glasses | | Not Covered | Not Covered | —————none————— |
| Dental check-up | | Not Covered | Not Covered | —————none————— |

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 1-800-451-1527. 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.

Questions: Call 1-800-451-1527 or visit us at www.anthem.com

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

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

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwoł únizinigo t'áá diné k'éjíggo, t'áá shoodí ba na'aln'íhí ya sidáhí bich'í naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aalagú bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'núilígú bi'kéhgo bich'í hodiilní.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

Questions: Call 1-800-451-1527 or visit us at www.anthem.com

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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 \$5,120
- Patient pays \$2,420

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 | \$1,000 |
| Copays | \$20 |
| Coinsurance | \$1,250 |
| Limits or exclusions | \$150 |
| Total | \$2,420 |

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

- Amount owed to providers: \$5,400
- Plan pays \$3,420
- Patient pays \$1,980

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 | \$1,000 |
| Copays | \$540 |
| Coinsurance | \$360 |
| Limits or exclusions | \$80 |
| Total | \$1,980 |

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: www.anthem.com or 1-800-451-1527.

Questions: Call 1-800-451-1527 or visit us at www.anthem.com

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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.

Questions: Call 1-800-451-1527 or visit us at www.anthem.com

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-451-1527.

| Important Questions | Answers | Why this Matters: |
|---|--|---|
| What is the overall <u>deductible</u> ? | \$1,300 Individual/ \$2,600 Family for Network providers and Out of Network providers. | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| Is there an <u>out-of-pocket limit</u> on my expenses? | Yes. \$3,425 Individual/ \$6,850 Family for Network providers. \$5,000 Individual/ \$10,000 Family for Out of Network providers. | The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ? | Premiums, Balance-billed charges and Health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| 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 <i>specific</i> covered services, such as office visits. |
| Does this plan use a <u>network of providers</u> ? | Yes. See www.anthem.com or call 1-800-451-1527 for a list of Network providers. | If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> . |
| Do I need a referral to see a <u>specialist</u> ? | No. You don't need a referral to see a specialist. | You can see the <u>specialist</u> you choose without permission from this plan. |

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| | | |
|---|------|--|
| 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 <u>excluded services</u> . |
|---|------|--|

- 
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 an Out of Network Provider | Limitations & Exceptions |
|---|--|---|---|---|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Specialist visit | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Other practitioner office visit | 20% Coinsurance for Chiropractor | 40% Coinsurance for Chiropractor | Coverage is limited to 30 visits per benefit period. Acupuncture is not covered. |
| | Preventive care/screening/immunization | No Charge | 40% Coinsurance | —————none————— |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance | 40% Coinsurance | —————none————— |
| If you need drugs to treat your illness or condition | Generic drugs | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Preferred brand drugs | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Non-preferred brand drugs | 20% Coinsurance | 40% Coinsurance | —————none————— |

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Montgomery County Lumenos HSA

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2016 - 09/30/2017

Coverage for: Individual/Family | Plan Type: HSA

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use an Out of Network Provider | Limitations & Exceptions |
|---|--|---|---|--------------------------|
| More information about prescription drug coverage is available at www.anthem.com | Specialty drugs | 20% Coinsurance | 40% Coinsurance | —————none————— |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Physician/surgeon fees | 20% Coinsurance | 40% Coinsurance | —————none————— |
| If you need immediate medical attention | Emergency room services | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Emergency medical transportation | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Urgent care | 20% Coinsurance | 40% Coinsurance | —————none————— |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Physician/surgeon fee | 20% Coinsurance | 40% Coinsurance | —————none————— |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Mental/Behavioral health inpatient services | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Substance Abuse disorder outpatient services | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Substance Abuse disorder inpatient services | 20% Coinsurance | 40% Coinsurance | —————none————— |
| If you are pregnant | Prenatal and postnatal care | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Delivery and all inpatient services | 20% Coinsurance | 40% Coinsurance | —————none————— |

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Montgomery County Lumenos HSA

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 10/01/2016 - 09/30/2017

Coverage for: Individual/Family | Plan Type: HSA

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use an Out of Network Provider | Limitations & Exceptions |
|---|---------------------------|---|---|---|
| If you need help recovering or have other special health needs | Home health care | 20% Coinsurance | 40% Coinsurance | Coverage is limited to 90 visits per benefit period. |
| | Rehabilitation services | 20% Coinsurance | 40% Coinsurance | Coverage is limited to a combined 30 visits per benefit period for Occupational and Physical therapy services. Coverage is limited to 30 visits per benefit period for Speech therapy services. |
| | Habilitation services | 20% Coinsurance | 40% Coinsurance | Coverage is limited to a combined 30 visits per benefit period for Occupational and Physical therapy services. Coverage is limited to 30 visits per benefit period for Speech therapy services. |
| | Skilled nursing care | 20% Coinsurance | 40% Coinsurance | Coverage is limited to 100 days per benefit period. |
| | Durable medical equipment | 20% Coinsurance | 40% Coinsurance | —————none————— |
| | Hospice service | 20% Coinsurance | 40% Coinsurance | —————none————— |
| If your child needs dental or eye care | Eye exam | \$15 Copay/Visit | Balance-billed charges after \$30 benefit maximum | Out-of-Network benefit not subject to deductible. |
| | Glasses | Not Covered | Not Covered | —————none————— |
| | Dental check-up | Not Covered | Not Covered | —————none————— |

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

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- Chiropractic care
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- 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 1-800-451-1527. 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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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 adoolwol íinízinigo t'áá diné k'éjígó, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíílkíid. Eí doo biigha daago ni ba'nija'go ho'aalagú bich'í hodiilní. Hai'daq iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'niilígú bi'kéhgo bich'í hodiilní.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

Questions: Call 1-800-451-1527 or visit us www.anthem.com.

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Having a baby

(normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,890
- Patient pays \$2,650

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 | \$1,300 |
| Copays | \$0 |
| Coinsurance | \$1,200 |
| Limits or exclusions | \$150 |
| Total | \$2,650 |

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,230
- Patient pays \$2,170

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 | \$1,300 |
| Copays | \$0 |
| Coinsurance | \$790 |
| Limits or exclusions | \$80 |
| Total | \$2,170 |

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: www.anthem.com or 1-800-451-1527.

Questions: Call 1-800-451-1527 or visit us 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 1-800-451-1527 to request a copy.

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.

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