



The Summary of Benefits and Coverage (SBC) document will help you choose a health **plan**. The SBC shows you how you and the **plan** would share the cost for covered health care services. **NOTE: Information about the cost of this **plan** (called the **premium**) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, <https://eoc.anthem.com/eocdps/9Y7ESMG01012024>. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (855) 330-1105 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$3,250/person or \$6,500/family for In- <u>Network</u> <u>Providers</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Primary Care. <u>Specialist</u> Visit. <u>Preventive Care</u> . Vision. For more information see below.	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$200/person or \$400/family for <u>Prescription Drugs</u> In- <u>Network</u> <u>Providers</u> . There are no other specific <u>deductibles</u> .	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.
What is the out-of-pocket limit for this plan?	\$9,450/person or \$18,900/family for In- <u>Network</u> <u>Providers</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> 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> .
Will you pay less if you use a network provider?	Yes. See www.anthembluecross.com/find-care/?alphaprefix=YXE or call (855) 330-1105 for a list of <u>network providers</u> . Costs may vary by site of service and how the <u>provider</u> bills.	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a referral to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .
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 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40/visit, <u>deductible</u> does not apply	Not covered	Hospital clinics are not covered. Virtual visits (Telehealth) benefits available.
	<u>Specialist</u> visit	\$80/visit, <u>deductible</u> does not apply	Not covered	Virtual visits (Telehealth) benefits available.
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab – Office \$20/visit, <u>deductible</u> does not apply X-Ray – Office \$75/visit	Lab – Office Not covered X-Ray – Office Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	50% <u>coinsurance</u>	Not covered	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Typically Generic (Tier 1)	\$25/prescription, Prescription Drug <u>deductible</u> does not apply (retail) and \$63/prescription, Prescription Drug <u>deductible</u> does not apply (home delivery)	Not covered (retail and home delivery)	For more information, refer to “Traditional Open Drug List” at http://www.anthem.com/pharmacyinformation/ *See Prescription Drug section
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$75/prescription, Prescription Drug <u>deductible</u> applies (retail) and \$188/prescription, Prescription Drug <u>deductible</u> applies (home delivery)	Not covered (retail and home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	\$90/prescription, Prescription Drug <u>deductible</u> applies (retail) and \$225/prescription, Prescription Drug <u>deductible</u> applies (home delivery)	Not covered (retail and home delivery)	

* For more information about limitations and exceptions, see the **plan** or policy document at <https://eoc.anthem.com/eocdps/9Y7ESMG01012024>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <u>coinsurance</u>	Not covered	\$300/visit for Ambulatory Surgical Center.
	Physician/surgeon fees	50% <u>coinsurance</u>	Not covered	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	50% <u>coinsurance</u>	Covered as In- <u>Network</u>	-----none-----
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>	Covered as In- <u>Network</u>	-----none-----
	<u>Urgent care</u>	\$80/visit, <u>deductible</u> does not apply	Covered as In- <u>Network</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <u>coinsurance</u>	Not covered	60 days/benefit period for Inpatient rehabilitation for In- <u>Network Providers</u> .
	Physician/surgeon fees	50% <u>coinsurance</u>	Not covered	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$40/visit, <u>deductible</u> does not apply Other Outpatient No charge	Office Visit Not covered Other Outpatient Not covered	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	50% <u>coinsurance</u>	Not covered	-----none-----
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . 50% <u>coinsurance</u> for Postnatal In- <u>Network Providers</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	50% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	50% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$80/visit, <u>deductible</u> does not apply	Not covered	40 visits/benefit period for In- <u>Network Providers</u> .
	<u>Rehabilitation services</u>	\$40/visit, <u>deductible</u> does not apply	Not covered	*See Therapy Services section.
	<u>Habilitation services</u>	\$40/visit, <u>deductible</u> does not apply	Not covered	
	<u>Skilled nursing care</u>	50% <u>coinsurance</u>	Not covered	-----none-----
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	Not covered	*See <u>Durable Medical Equipment</u> Section
	<u>Hospice services</u>	50% <u>coinsurance</u>	Not covered	-----none-----
If your child	Children's eye exam	No charge	Not covered	*See Vision Services section

* For more information about limitations and exceptions, see the **plan** or policy document at <https://eoc.anthem.com/eocdps/9Y7ESMG01012024>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
needs dental or eye care	Children's glasses	No charge	Not covered	
	Children's dental check-up	0% <u>coinsurance</u>	Not covered	*See Dental Services section

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids are limited to 1 purchase (including repair/replacement) once every 3 years (In-Network)
- Infertility treatment – certain services
- Private-duty nursing in a Home Setting only
- Routine eye care (Adult) 1 exam/benefit period

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: New York State Department of Financial Services, One State Street, New York, NY 10004-1511, (800) 342-3736, (212) 480-6400, (518) 474-6600, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, or contact Anthem at the number on the back of your ID card. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 1407, Church Street Station, New York, NY 10008-1407

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

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/9Y7ESMG01012024>.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,250
■ <u>Specialist copayment</u>	\$80
■ Hospital (facility) <u>coinsurance</u>	50%
■ Other <u>copayment</u>	\$20

This **EXAMPLE** event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,250
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$4,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$7,710

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,250
■ <u>Specialist copayment</u>	\$80
■ Hospital (facility) <u>coinsurance</u>	50%
■ Other <u>copayment</u>	\$20

This **EXAMPLE** event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$2,200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,420

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,250
■ <u>Specialist copayment</u>	\$80
■ Hospital (facility) <u>coinsurance</u>	50%
■ Other <u>copayment</u>	\$20

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,100
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,500

The plan would be responsible for the other costs of these **EXAMPLE** covered services.