**700 Anthem EPO Plan**

**Coverage for:** Individual, Family | **Plan Type:** EPO

**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, call 1-878-222-4410. 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 1-878-222-4410 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: $700 individual / $1,400 family<br>Out-of-Network: Not Covered | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible (embedded). |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and primary care services are covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | In-Network: $6,600 individual / $13,200 family<br>Out-of-Network: Not Covered | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met (embedded). |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, and health care this plan does not cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.BCBS.com or call 1-878-222-4410 for a list of participating providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

All coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event | Services You May Need | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $45 co-pay/visit | Not covered | ———————————— |
| | Specialist visit | $45 co-pay/visit | Not covered | ———————————— |
| | Preventive care/screening/immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Deductible then 20% coinsurance | Not covered | Diagnostic testing done during an office visit is covered at 100%. |
| | Imaging (CT/PET scans, MRIs) | Deductible then 20% coinsurance | Not covered | Pre-authorization is required. |
| **If you need drugs to treat your illness or condition** More information about prescription drug coverage is available at www.carelonrx.com | Generic drugs (Tier 1) | Retail: $15 co-pay/prescription<br>Mail Order: $30 co-pay/prescription | Not covered | Medical out-of-pocket limit applies. Covers up to a 30-day supply (retail & specialty); 31–90 day supply (mail order). Once the medical annual out-of-pocket limit is met, you pay nothing for covered prescription medication. |
| | Preferred brand drugs (Tier 2) | Retail: $30 co-pay/prescription<br>Mail Order: $60 co-pay/prescription | Not covered | Medical out-of-pocket limit applies. Covers up to a 30-day supply (retail & specialty); 31–90 day supply (mail order). Once the medical annual out-of-pocket limit is met, you pay nothing for covered prescription medication. |
| | Non-preferred brand drugs (Tier 3) | Retail: $60 co-pay/prescription<br>Mail Order: $120 co-pay/prescription | Not covered | Medical out-of-pocket limit applies. Covers up to a 30-day supply (retail & specialty); 31–90 day supply (mail order). Once the medical annual out-of-pocket limit is met, you pay nothing for covered prescription medication. |
| | Specialty drugs (Tier 4) | Generic: $15 co-pay/prescription | Not covered | Specialty drugs are covered through BioPlus. |

| Common Medical Event | Services You May Need | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Deductible then 20% coinsurance | Not covered | Pre-authorization is required for some services. |
| | Physician/surgeon fees | Deductible then 20% coinsurance | Not covered | ———————— |
| **If you need immediate medical attention** | Emergency room care | $150 co-pay/visit | $150 co-pay/visit | Copay waived if admitted. |
| | Emergency medical transportation | Deductible then 20% coinsurance | Deductible then 20% coinsurance | ———————— |
| | Urgent care | $45 co-pay/visit | Not covered | ———————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Deductible then 20% coinsurance | Not covered | Pre-authorization is required. |
| | Physician/surgeon fees | Deductible then 20% coinsurance | Not covered | ———————— |
| **If you need mental health, behavioral health, or substance abuse services** | Office services | $45 co-pay/visit | Not covered | ———————— |
| | Inpatient/Outpatient services | Deductible then 20% coinsurance | Not covered | Pre-authorization required for inpatient. |
| **If you are pregnant** | Office visits | $45 co-pay/visit | Not covered | Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Copay applies to initial visit to confirm pregnancy, then all other prenatal visits are covered at 100%. |
| | Childbirth/delivery professional services | Deductible then 20% coinsurance | Not covered | ———————— |
| | Childbirth/delivery facility services | Deductible then 20% coinsurance | Not covered | Pre-authorization is required for vaginal deliveries requiring more than a 48-hour stay and for cesarean section deliveries requiring more than a 96-hour stay in order to avoid a denial of services. |

| Common Medical Event | Services You May Need | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | Deductible then 20% coinsurance | Not covered | Pre-authorization is required. Limited to a maximum of 200 visits per year. |
| | Rehabilitation services | Office: $45 co-pay/visit<br>Outpatient/Inpatient: Deductible then 20% coinsurance | Not covered | Pre-authorization is required for initial visit. Physical therapy, occupational therapy, respiratory therapy & speech therapy have separate limit of 30 visits per year. |
| | Habilitation services | Office: $45 co-pay/visit<br>Outpatient/Inpatient: Deductible then 20% coinsurance | Not covered | Pre-authorization is required for initial visit. Physical therapy, occupational therapy, respiratory therapy & speech therapy have separate limit of 30 visits per year. |
| | Skilled nursing care | Deductible then 20% coinsurance | Not covered | Pre-authorization is required. |
| | Durable medical equipment | Deductible then 20% coinsurance | Not covered | Pre-authorization is required for items over $2,500. |
| | Hospice services | Deductible then 20% coinsurance | Not covered | Pre-authorization required. Limited to a maximum of 210 visits per lifetime. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | ——— |
| | Children's glasses | Not covered | Not covered | ——— |
| | Children's dental check-up | Not covered | Not covered | ——— |

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

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

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

- Abortion
- Chiropractic care
- Hearing aids (limited to 1 per ear per lifetime)
- Infertility treatment (limited to 3 treatments per lifetime combined with artificial insemination and in vitro fertilization)
- Private-duty nursing

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 the plan at 1-878-222-4410. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage? Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-878-222-4410.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-878-222-4410.
Navajo (Diné): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-878-222-4410.

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

**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 plan's overall deductible** **$700**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $700 |
| Copayments | $45 |
| Coinsurance | $2,200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$2,945** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$700**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $700 |
| Copayments | $480 |
| Coinsurance | $500 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,680** |

### Mia's Simple Fracture
(in-network emergency room visit and follow-up care)

- **The plan's overall deductible** **$700**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $700 |
| Copayments | $330 |
| Coinsurance | $140 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,170** |

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