**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/0V8VSMG01012027. 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) 330-1103 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $5,000/person or $10,000/family for In-Network Providers. $10,000/person or $20,000/family for Out-of-Network Providers. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Primary Care. Specialist Visit. Preventive Care. Vision. For more information see below. | 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?** | Yes. $250/person or $500/family for Prescription Drugs. There are no other specific deductibles. | 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. |
| **What is the out-of-pocket limit for this plan?** | $10,500/person or $21,000/family for In-Network Providers. $21,000/person or $42,000/family for Out-of-Network Providers. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't 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.anthem.com/find-care/?alphaprefix=YGR or call (855) 330-1103 for a list of network providers. Benefits and | 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 |

| | | |
|---|---|---|
| | costs may vary by site of service and how the provider bills. | Provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Level 1 Pharmacy- RX Only (You will pay the least) | In-Network Provider (You will pay more) | Out-of-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 | Not Applicable | PPC $20/visit, deductible does not apply PCP $40/visit, deductible does not apply | 30% coinsurance | Please see http://www.anthem.com for a list of Preferred Primary Care (PPC) Providers. Copayment waived for members under 19 years old. Virtual visits (Telehealth) benefits available. |
| | Specialist visit | Not Applicable | $80/visit, deductible does not apply | 30% coinsurance | Virtual visits (Telehealth) benefits available. |
| | Preventive care/screening/ immunization | Not Applicable | No charge, deductible does not apply | 30% coinsurance | Prescribed FDA approved contraceptives are not subject to cost shares. 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) | Not Applicable | $80/visit, deductible does not apply | 30% coinsurance | --------none-------- |
| | Imaging (CT/PET scans, MRIs) | Not Applicable | $500/visit, deductible does not apply | 30% coinsurance | --------none-------- |
| **If you need drugs to treat your illness or** | Typically Lower Cost Generic (Tier 1a) | $5/prescription, Prescription Drug deductible does not | $15/prescription, Prescription Drug deductible does not | 50% coinsurance, Prescription Drug | For more information, refer to "Select Drug List" at https://www.anthem.com/phar |

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/0V8VSMG01012027.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Level 1 Pharmacy- RX Only (You will pay the least) | In-Network Provider (You will pay more) | Out-of-Network Provider (You will pay the most) | |
| **condition** More information about **prescription drug coverage** is available at https://www.anthem.com/pharmacy-information/. | | apply (retail) and $10/prescription, Prescription Drug deductible does not apply (home delivery) | apply (retail only) | deductible does not apply (retail only) | macy-information/. *See Prescription Drug section. |
| | Typically Generic (Tier 1b) | $30/prescription, Prescription Drug deductible does not apply (retail) and $60/prescription, Prescription Drug deductible does not apply (home delivery) | $40/prescription, Prescription Drug deductible does not apply (retail only) | 50% coinsurance, Prescription Drug deductible does not apply (retail only) | |
| | Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2) | $80/prescription, Prescription Drug deductible applies (retail) and $160/prescription, Prescription Drug deductible applies (home delivery) | $90/prescription, Prescription Drug deductible applies (retail only) | 50% coinsurance, Prescription Drug deductible does not apply (retail only) | |
| | Typically Non-Preferred Brand and Generic drugs (Tier 3) | 30% coinsurance up to $400/prescription, Prescription Drug deductible applies (retail) and 30% coinsurance up to $800/prescription, Prescription Drug deductible applies (home delivery) | 40% coinsurance up to $500/prescription, Prescription Drug deductible applies (retail only) | 50% coinsurance, Prescription Drug deductible does not apply (retail only) | |

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/0V8VSMG01012027.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Level 1 Pharmacy- RX Only (You will pay the least) | In-Network Provider (You will pay more) | Out-of-Network Provider (You will pay the most) | |
| | Typically Preferred Specialty (brand and generic) (Tier 4) | 40% coinsurance up to $550/prescription, Prescription Drug deductible applies (retail and home delivery) | 50% coinsurance up to $650/prescription, Prescription Drug deductible applies (retail only) | 50% coinsurance, Prescription Drug deductible does not apply (retail only) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not Applicable | $1,000/visit, deductible does not apply | 30% coinsurance | --------none-------- |
| | Physician/surgeon fees | Not Applicable | No charge | 30% coinsurance | --------none-------- |
| **If you need immediate medical attention** | Emergency room care | Not Applicable | $800/visit | Covered as In-Network | Copayment waived if admitted. |
| | Emergency medical transportation | Not Applicable | $800/trip | Covered as In-Network | Non-emergency Out-of-Network Ambulance Services are limited to $50,000 per trip, does not apply to air ambulance. |
| | Urgent care | Not Applicable | $150/visit, deductible does not apply | 30% coinsurance | --------none-------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not Applicable | $1,500/admission | 30% coinsurance | --------none-------- |
| | Physician/surgeon fees | Not Applicable | 0% coinsurance | 30% coinsurance | --------none-------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Not Applicable | Office Visit $80/visit, deductible does not apply<br>Other Outpatient $500/visit, deductible does not apply | Office Visit 30% coinsurance<br>Other Outpatient 30% coinsurance | Office Visit Copayment waived for members under 19 years old. Virtual visits (Telehealth) benefits available.<br>Other Outpatient --------none-------- |
| | Inpatient services | Not Applicable | $1,500/admission | 30% coinsurance | --------none-------- |
| | Office visits | Not Applicable | No charge | 30% coinsurance | |

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/0V8VSMG01012027.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Level 1 Pharmacy- RX Only (You will pay the least) | In-Network Provider (You will pay more) | Out-of-Network Provider (You will pay the most) | |
| **If you are pregnant** | Childbirth/delivery professional services | Not Applicable | $500/pregnancy, deductible does not apply | 30% coinsurance | Cost sharing does not apply for In-Network preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery facility services | Not Applicable | $1,500/admission | 30% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | Not Applicable | $80/visit, deductible does not apply | 30% coinsurance | --------none-------- |
| | Rehabilitation services | Not Applicable | $40/visit, deductible does not apply | 30% coinsurance | *See Therapy Services section. |
| | Habilitation services | Not Applicable | $40/visit, deductible does not apply | 30% coinsurance | |
| | Skilled nursing care | Not Applicable | $1,500/admission | 30% coinsurance | 100 days/benefit period for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined. |
| | Durable medical equipment | Not Applicable | $300/visit | 30% coinsurance | *See Durable Medical Equipment section. |
| | Hospice services | Not Applicable | $80/visit, deductible does not apply | 30% coinsurance | --------none-------- |
| **If your child needs dental or eye care** | Children's eye exam | Not Applicable | No charge, deductible does not apply | $0 copayment up to plan's Maximum Allowed Amount | *See Vision Services section. |

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/0V8VSMG01012027.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Level 1 Pharmacy- RX Only (You will pay the least) | In-Network Provider (You will pay more) | Out-of-Network Provider (You will pay the most) | |
| | Children's glasses | Not Applicable | No charge, deductible does not apply | $0 copayment up to plan's Maximum Allowed Amount | |
| | Children's dental check-up | Not Applicable | 0% coinsurance | 30% coinsurance | *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
- Private-duty nursing
- Routine foot care unless medically necessary
- Weight loss programs

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

- Abortion
- Acupuncture 20 visits/benefit period
- Bariatric surgery
- Chiropractic care 36 visits/benefit period
- Hearing aids
- Infertility treatment
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- 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 Hampshire Insurance Department, 21 So Fruit St, Suite 14, Concord, NH 03301, Consumer Hotline (800) 852-3416, 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 518, North Haven, CT 06473-0518

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/0V8VSMG01012027.

New Hampshire Insurance Department, 21 So Fruit St, Suite 14, Concord, NH 03301, Consumer Hotline (800) 852-3416

Additionally, a consumer assistance program can help you file your appeal. Contact New Hampshire State Insurance Department 21 South Fruit Street, Suite 14, Concord, NH 03301, (800) 852-3416, TTY/TDD Relay Services: (800) 735-2964, http://www.nh.gov/insurance/, consumerservices@ins.nh.gov

**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.

***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** **$5,000**
- **Specialist copayment** **$80**
- **Hospital (facility) copayment** **$1,500**
- **Other copayment** **$80**

**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 | $5,000 |
| Copayments | $2,800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$7,860** |

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

- **The plan's overall deductible** **$5,000**
- **Specialist copayment** **$80**
- **Hospital (facility) copayment** **$1,500**
- **Other copayment** **$80**

**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 | $250 |
| Copayments | $2,300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,570** |

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

- **The plan's overall deductible** **$5,000**
- **Specialist copayment** **$80**
- **Hospital (facility) copayment** **$1,500**
- **Other copayment** **$80**

**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 | $1,900 |
| Copayments | $600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| 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.

## We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

**Spanish**
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

**Chinese**
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

**Vietnamese**
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

**Korean**
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

**Tagalog**
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

**Russian**
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

**French Creole**
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

**Arabic**
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

**French**
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

**Persian**
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

**Armenian**
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

**Japanese**
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

**Italian**
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

**German**
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

**Polish**
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

**Pennsylvania Dutch**
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

**TTY/TTD:711**

### It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf