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.itpeubenefits.com or by calling 1-800-327-5926.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$**450** Individual for In or Out of Network providers $**900** Family for In or Out of Network providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. Combined family members may meet both **deductibles**.
Are there other deductibles for specific services?	Pharmacy $225 Dental $175	The plan begins coverage for these services after the deductible has been met
Is there an out–of–pocket limit on my expenses?	Yes. **$5,000** Individual for In and Out of Network providers **$10,000** Family for In and Out of Network providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Combined family members may meet the **out of pocket** maximum.
What is not included in the out–of–pocket limit?	Employer Contributions, Balance-billed charges, Services deemed not medically necessary by Medical Management are not covered by this plan.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an annual limit on claims the plan pays?	No.	The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.anthem.com or call 1-877-331-4329 for a list of In Network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **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 25% would be $250. 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**.) We allow usual and customary charges.
- 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	25% Coinsurance	35% Coinsurance	————none————
	Specialist visit	25% Coinsurance	35% Coinsurance	————none————
	Other practitioner office visit	25% Coinsurance for Acupuncture and Chiropractor	35% Coinsurance for Acupuncture and Chiropractor	Coverage is limited to 30 visits per year for Occupational, Physical therapy and Chiropractor. Coverage is limited to 20 visits per calendar year for Speech therapy.
	Preventive care/screening/immunization	No Charges	35% Coinsurance	For more information refer to your SPD at www.itpeubenefits.com
If you have a test	Diagnostic test (x-ray, blood work)	25% Coinsurance	35% Coinsurance	For more information refer to your SPD at www.itpeubenefits.com
	Imaging (CT/PET scans, MRIs)	25% Coinsurance	35% Coinsurance	Pre-certification is required
Is there an out-of-pocket limit on my expenses? More information about prescription drug coverage is available at **www.itpeubenefits.com** 1-800-327-5926	Yes. $2,550 Individual / $5,100 Family Generic drugs	30% Coinsurance	30% Coinsurance	For more information refer to your SPD at www.itpeubenefits.com
	$2,550 Individual / $5,100 Family Preferred brand drugs	30% Coinsurance	30% Coinsurance	For more information refer to your SPD at www.itpeubenefits.com
	$2,550 Individual / $5,100 Family Non-preferred brand drugs	30% Coinsurance	30% Coinsurance	For more information refer to your SPD at www.itpeubenefits.com
	$2,550 Individual / $5,100 Family Specialty drugs	30% Coinsurance	30% Coinsurance	For more information refer to your SPD at www.itpeubenefits.com
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% Coinsurance	35% Coinsurance	For more information refer to your SPD at www.itpeubenefits.com
	Physician/surgeon fees	25% Coinsurance	35% Coinsurance	For more information refer to your SPD at www.itpeubenefits.com
If you need immediate medical attention	Emergency room services	25% Coinsurance	25% Coinsurance	For more information refer to your SPD at www.itpeubenefits.com
	Emergency medical transportation	25% Coinsurance	25% Coinsurance	For more information refer to your SPD at www.itpeubenefits.com
	Urgent care	25% Coinsurance	35% Coinsurance	For more information refer to your SPD at www.itpeubenefits.com

Common Medical Event	Services You May Need	Your Cost If You Use an In Network Provider	Your Cost If You Use an Out of Network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	25% Coinsurance	35% Coinsurance	Pre-certification is required
	Physician/surgeon fee	25% Coinsurance	35% Coinsurance	For more information refer to your SPD at www.itpeubenefits.com
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not Covered	Not Covered	————————none————————
	Mental/Behavioral health inpatient services	Not Covered	Not Covered	————————none————————
	Substance abuse disorder outpatient services	Not Covered	Not Covered	————————none————————
	Substance abuse disorder inpatient services	Not Covered	Not Covered	————————none————————
If you are pregnant	Prenatal and postnatal care	25% Coinsurance	35% Coinsurance	There may be other levels of cost share that are contingent on how services are provided. For more information refer to your SPD at www.itpeubenefits.com
	Delivery and all inpatient services	25% Coinsurance	35% Coinsurance	Pre-certification is required.
If you need help recovering or have other special health needs	Home health care	25% Coinsurance	35% Coinsurance	120 days maximum
	Rehabilitation services	25% Coinsurance	35% Coinsurance	Coverage is limited to 30 visits per year for Occupational, Physical therapy and Chiropractor. Coverage is limited to 20 visits per calendar year for Speech therapy.
	Habilitation services	25% Coinsurance	35% Coinsurance	Coverage is limited to 30 visits per year for Occupational, Physical therapy and Chiropractor. Coverage is limited to 20 visits per calendar year for Speech therapy.
	Skilled nursing care	25% Coinsurance	35% Coinsurance	120 days maximum
	Durable medical equipment	25% Coinsurance	35% Coinsurance	For more information refer to your SPD at www.itpeubenefits.com
	Hospice service	Not Covered	Not Covered	————————none————————
If you have dental or eye care Questions go to: www.itpeubenefits.com 1-800-327-5926	Vision Benefit	Covered	Covered	$150 Maximum Employee only **(every 24 months)**
	Dental Benefit	30% Coinsurance 45% Coinsurance prosthetics	30% Coinsurance 45% Coinsurance prosthetics	$500 Maximum Employee $250 Maximum Dependent

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.)

- Bariatric Surgery
- Cosmetic Surgery
- Infertility treatment
- Long-term care
- Private duty nursing
- Hearing Aids
- 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.)

- Acupuncture
- Chiropractic care
- Dental Care
- Most coverage provided outside the United States.
  See www.bcbs.com/bluecardworldwide
- Non-emergency care when traveling outside the U.S.
- Routine eye care

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 1-800-327-5926. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-800-537-8183 or www.dol.gov/ebsa , or the U.S. Department of Health and Human Services at 1-800-233-4947 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 BCBS

P.O. Box 105568

Atlanta, GA 30348.

Language Access Services:

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

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

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

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,317
- **Patient pays** $2,223

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	$450
Copays	$0
Coinsurance	$1,773
Limits or exclusions	$0
Total	**$2,223**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,622
- **Patient pays** $1,778

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	$225
Copays	$0
Coinsurance	$1,553
Limits or exclusions	$0
Total	**$1,778**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include employer **contributions**.
- 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 **contribution** your employer pays. Generally, the lower the **contribution**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**.