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.fringebenefitsonline.com or by calling **1-888-221-2201**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	PPO Provider and Non-PPO combined: **$750**/person; **$1,500**/family. Does not apply to PPO preventive care, prescription drugs, PPO office visits, hearing services, and some therapies. Balance billing, excluded services, penalty for failure to precertify, coinsurance amounts and copays do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, the **Out-of-Pocket Limit** for cost-sharing for PPO copays, coinsurance and deductibles per calendar year is **$6,600**/individual; **$13,200**/family. This includes a coinsurance maximum of PPO **$2,000** Individual/**$4,000** Family (applies to coinsurance for medical expenses) as well as a **$1,500** Individual/**$3,000** family **Out-of-Pocket Limit** for in-network prescription drugs. This plan has no **Out-of-Pocket limit** for cost-sharing for Non-PPO providers (or pharmacies). However, there is a Non-PPO coinsurance maximum of **$4,000** Individual/**$8,000** Family.	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.
What is not included in the out–of–pocket limit?	The **Out-of-Pocket Limit** for PPO cost-sharing does not accumulate premiums, balance-billed charges, non-covered expenses, charges in excess of benefit maximums, penalty for failure to obtain precertification, dental plan expenses, and out-of-network deductibles, copays and coinsurance except ER visit in cases of an emergency.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. For a list of **PPO providers, see www.anthem.com, or call 1-888-221-2201.**	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 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 6. 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.
- **Co-insurance** 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 **co-insurance** 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 PPO **providers** by charging you lower **deductibles**, **copayments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use Non-PPO Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	40% coinsurance	Deductible does not apply to PPO office visits.
	Specialist visit	$45 copay/visit	40% coinsurance	
	Other practitioner office visit	20% coinsurance for chiropractor	40% coinsurance for chiropractor	Coverage limited to 12 chiropractic visits/person/year. Acupuncture is not covered.
	Preventive care/screening/ Immunization	No charge	Not covered	Covers Health Care Reform required preventive services at 100%. Deductible does not apply to PPO services.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Covered only when ordered by a Physician or Health Care Practitioner.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Precertification is required to avoid a $200 penalty.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use Non-PPO Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from Express Scripts www.express-scripts.com or call 1-877-551-8811.	Generic drugs	Retail: 20% coinsurance, minimum copay of $10/prescription; Mail: $20 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 31-90-day supply (mail order prescription). No charge for generic FDA-approved brand contraceptives (or brand name if generic is medically inappropriate).
	Brand formulary drugs	Retail: 30% coinsurance, minimum copay of $20/prescription; Mail: $40 copay/prescription	Not covered	• Covers up to a 30-day supply (retail prescription; 31-90-day supply (mail order prescription). • If you select a brand drug when a generic is available, and your Provider did not require the brand drug, you will be required to pay the difference between the cost of the brand drug and the generic drug, in addition to any coinsurance or copays. This amount will not accumulate to the Out-of-Pocket maximum. • No charge for FDA-approved brand contraceptive if generic is medically inappropriate.
	Brand Non-formulary drugs	Retail: 50% coinsurance, minimum copay of $40/prescription; Mail: $80 copay/prescription	Not covered	
	Specialty drugs	$75 copay/prescription	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Precertification is required to avoid a $200 penalty
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Assistant Surgeon: you pay 20% of the eligible expenses allowed for the primary surgeon or 10% for a Physician Assistant, surgical assistant or a registered nurse.
If you need immediate medical attention	Emergency room services	$100 copay/visit and 20% coinsurance	$100 copay/visit and 20% coinsurance	Must be for emergency service as defined by the Plan. $100 copay/visit is waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Must be for emergency service as defined by the Plan.
	Urgent care	$45 copay/visit	40% coinsurance	Deductible does not apply to PPO services.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use Non-PPO Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification is required to avoid a $200 penalty. Coverage generally only provided for semi-private room.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Assistant Surgeon: you pay 20% for the primary surgeon, or 10% for a Physician Assistant, surgical assistant or a registered nurse.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/visit, 20% coinsurance for other outpatient services	40% coinsurance	Deductible does not apply to PPO office visits. Certain court-ordered treatment not covered.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Precertification is required to avoid a $200 penalty. Coverage is generally only provided for semi-private rooms. Certain court-ordered treatment not covered.
	Substance use disorder outpatient services	$30 copay/visit, 20% coinsurance for other outpatient services	40% coinsurance	Deductible does not apply to PPO office visits. Certain court-ordered treatment not covered.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Precertification is required to avoid a $200 penalty. Coverage is generally only provided for semi-private rooms. Certain court-ordered treatment not covered.
If you are pregnant	Prenatal and postnatal care	No charge	No coverage for female preventive care screenings, all other services 40% coinsurance after the deductible.	Ultrasounds covered as imaging services. Coverage includes some gestational diabetes screenings. Coverage does not include Lamaze classes.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Precertification is required if extended stay is expected to avoid a $200 penalty.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use Non-PPO Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Maximum of 100 days/year in lieu of inpatient care or skilled nursing facility care. Provider must certify initially and periodically.
	Rehabilitation services	20% coinsurance	40% coinsurance	Maximum of 20 visits/year (more than 20 visits in limited circumstances). Inpatient fees may apply if services received in an inpatient setting.
	Habilitation services	20% coinsurance	40% coinsurance	Deductible does not apply to PPO and Non-PPO services. 20 visits per type of therapy for congenital defects and birth abnormalities (only available from third birthday to sixth birthday).
	Skilled nursing care	20% coinsurance	40% coinsurance	Maximum of 60 days/year. Allowed amount based on prevailing semi-private room rate in confined area.
	Durable medical equipment	20% coinsurance	40% coinsurance	Rental of equipment is covered unless purchase is less expensive. Replacement allowed once in a 5 year period due to pathological changes or normal growth.
	Hospice service	20% coinsurance	40% coinsurance	Maximum of 8 days/lifetime for Respite Care and 6 visits for Licensed/Certified Social Worker.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Your employer must decide whether or not to offer vision benefits. If it does, coverage will be through a separate vision plan.
	Glasses	Not covered	Not covered	Your employer must decide whether or not to offer the vision benefits. If it does, coverage will be through a separate vision plan.
	Dental check-up	Not covered	Not covered	Dental benefits are separately insured. Your employer must decide whether or not to offer the dental benefits.

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 (unless your employer elects to include dental coverage)
- Infertility treatment
- Private duty nursing
- Routine eye care (unless your employer elects to include vision coverage)
- Routine foot care
- Weight loss programs (except as required under health reform)

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 (12 visits/per person per year)
- Hearing aids (for minor children with hearing loss)
- Non-emergency care when traveling outside the U.S. (if a resident of USA and traveling for vacation, business, or schooling)

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 1-888-221-2201. 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 the Administrative Office at 1-888-221-2201. 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 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:

Questions: Call **1-888-221-2201** or visit us at **www.fringebenefitsonline.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.fringebenefitsonline.com or** www.dol.gov/ebsa/healthreform or call 888-221-2201 to request a copy.

Spanish (Español): Para obtener asistencia en Español, llame al (888) 221-2201.

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** $5,590
- **Patient pays** $1,950

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	$750
Copays	$0
Coinsurance	$1,170
Limits or exclusions	$30
Total	**$1,950**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,630
- **Patient pays** $1,770

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	$750
Copays	$210
Coinsurance	$770
Limits or exclusions	$40
Total	**$1,770**

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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