Anthem BlueCross BlueShield
Blue Access – Saver Group Inc – Core Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 3/01/2017 – 2/28/2018
Coverage for: Single/Family | **Plan Type:** PPO

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 https://eoc.anthem.com/eocdps/aso or by calling 1- 888-650-4047.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For network providers **$1,000** single / **$2,000** family For non-network providers **$2,000** single / **$4,000** family Does not apply to In-Network Preventive Care, Hospice Care, In-Network Provider and Non-Network Provider deductibles are separate and do not count towards each other.	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 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 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	For network providers **$4,000** single / **$8,000** family For non-network providers **$8,000** singlge / **$16,000** family	The **out-of-pocket limit** is the most you could pay during a policy period 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?	Balance-Billed Charges, Health Care This Plan Doesn't Cover, Premiums, Costs Related to Prescription Drugs Covered Under the Prescription Drug Plan.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes specific coverage limits, such as limits on the number of office visits.

Does this plan use a network of providers?	Yes. For a list of **network providers**, see www.anthem.com or call 1-888-650-4047	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 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. 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.
- **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 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 **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network 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	40% coinsurance	——————none——————
	Specialist visit	$30 copay	40% coinsurance	——————none——————
	Other practitioner office visit	Chiropractic/ Manipulative Therapy $30 copay Acupuncturist Not covered	Chiropractic/ Manipulative Therapy 40% coinsurance Acupuncturist Not covered	Chiropractic/Manipulative Therapy Coverage is limited to 12 visits per year. Services from In-Network Provider and Non-Network Provider count towards your limit.
	Preventive care/screening/immunization	$30 copayment	40% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office No cost share X-Ray – Office No cost share	Lab – Office 40% coinsurance X-Ray – Office 40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Not subject to the deductible

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com	Generic drugs	$10/retail $20/home delivery	50% coinsurance; $60 minimum	Retail pharmacy 30 day supply, home delivery 90 day supply. Member may be responsible for additional cost when not selecting the available generic drug.
	Preferred brand drugs	$40/retail $100/home delivery	50% coinsurance; $60 minimum	
	Non-preferred brand drugs	$60/retail $150/ home delivery	50% coinsurance; $60 minimum	
	Specialty drugs	25% coinsurance up to $2,500 out-of-pocket maximum/retail and home delivery	Not Covered	Specialty drugs limited to 30 day supply regardless of whether they are retail or home delivery.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Not subject to the deductible
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Not subject to the deductible
If you need immediate medical attention	Emergency room services	$150 copayment/20% coinsurance	$150 copayment/20% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	$50 copayment	$50 copayment	Not subject to the deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Physical medicine and rehabilitation services (including day rehabilitation programs are limited to 60 days of care regardless of the provider's network status.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Medical visits 1/day

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $30 copay MentalBehavioral Health Facility Visit – Facility Charges 20% coinsurance	Mental/Behavioral Health Office Visit 40% coinsurance MentalBehavioral Health Facility Visit – Facility Charges 40% coinsurance	Not subject to the deductible
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	——————none——————
	Substance use disorder outpatient services	Substance Abuse Office Visit $30 copay Substance Abuse Facility Visit – Facility Charges 20% coinsurance	Substance Abuse Office Visit 40% coinsurance Substance Abuse Facility Visit – Facility Charges 40% coinsurance	Not subject to the deductible
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	——————none——————
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Your doctor's charges for delivery are part of prenatal and postnatal care.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Applies to inpatient facility. Other cost shares may apply depending on services provided.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Coverage is limited to 100 visits per year. Does not include I.V. therapy. Services from In-Network Provider and Non-Network Provider count towards your limit.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
	Rehabilitation services	20% coinsurance	40% coinsurance	Outpatient and office services count toward the limit. Limitations may vary by site of service. Your should refer to your formal contract of coverage for details. Services from In-Network Provider and Non-Network Provider count towards your limit. Physical, speech and occupational therapy 20 visit limit each; Pulmonary Rehabilitation 20 visit limit; Cardiac Rehabilitation 36 visit limit;
	Habilitation services	20% coinsurance	40% coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation visit limit
	Skilled nursing care	20% coinsurance	40% coinsurance	90 days network, non-network combined for skilled nursing facility.
	Durable medical equipment	20% coinsurance	40% coinsurance	————————none————————
	Hospice service	No Copayment/Coinsurance	No Copayment/Coinsurance	————————none————————
If your child needs dental or eye care	Eye exam	$30 copay	Not Covered	Coverage is for vision exam only. Consult your formal contract of coverage. Costs may vary by site of service. You should refer to your formal contract of coverage for details.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	——————none——————

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 (Adult)
- Hearing aids Except members under age 18 every 3 years. Consult your formal contract of coverage.
- Infertility treatment
- Long-term care
- 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.)

- Chiropractic care
- Private-duty nursing Limited to 82 visits/year and 164 visits/lifetime. Consult your formal contract of coverage.
- Routine eye care (adult) For vision exam only. Consult your formal contract of coverage.
- Most coverage provided outside the United States. See www.BCBS.com/bluecardworldwide

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- 888-650-4047. 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:

Anthem Blue Cross and Blue Shield, ATTN: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

Department of Labor's Employee Benefits Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform

1-855-333-5735

Additionally, a consumer assistance program can help you file your appeal. Contact:
Kentucky Department of Insurance, Consumer Protection Division
P.O. Box 517
Frankfort, KY 40602
(877) 587-7222
http://healthinsurancehelp.ky.gov
DOI.CAPOmbudsman@ky.gov

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** $5,330
- **Patient pays** $2,210

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	$1,000
Copays	$50
Coinsurance	$1,010
Limits or exclusions	$150
Total	**$2,210**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,530
- **Patient pays** $1,870

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	$1,000
Copays	$570
Coinsurance	$220
Limits or exclusions	$80
Total	**$1,870**

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.