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.anthem.com or by calling 1-800-552-9159.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,000** Single/**$8,000** Family for Network Providers. **$8,000** Single/**$16,000** Family for Non-Network Providers. Does not apply to Hospice, Network Preventive Care, Primary Care Visit and Specialist Visit. 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 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. **$5,000** Single/**$10,000** Family for Network Providers. **$10,000** Single/**$20,000** Family for Non-Network Providers. Network Provider and Non-Network Provider out-of-pocket are separate and do not count towards each other.	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?	Non-Network Human Organ and Tissue Transplant (HOTT) Services, Premiums, Balance-billed charges and Health care this plan doesn't cover.	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 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See **www.anthem.com** or call 1-800-552-9159 for a list of 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 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.
- **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	$20 Copay/Visit	40% Coinsurance	--------none--------
	Specialist visit	$30 Copay/Visit	40% Coinsurance	--------none--------
	Other practitioner office visit	Manipulative Therapy $30 Copay/Visit Acupuncturist Not Covered	Manipulative Therapy 40% Coinsurance Acupuncturist Not Covered	Manipulative Therapy Coverage is limited to 20 visits per Benefit Period combined Network and Non-Network Providers. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Preventive care/screening/immunization	No Cost Share	40% Coinsurance	--------none--------

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 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	Lab - Office Costs may vary by site of service. You should refer to your formal contract of coverage for details. X-Ray - Office Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Imaging (CT/PET scans, MRIs)	**20%** Coinsurance	**40%** Coinsurance	Costs may vary by site of service. You should refer to your formal contract of coverage for details.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert]	Tier 1 - Typically Generic			
	Tier 2 - Typically Preferred/Formulary Brand			
	Tier 3 - Typically Non-preferred/Non-formulary Drugs			
	Tier 4 - Typically Specialty Drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**20%** Coinsurance	**40%** Coinsurance	--------none--------
	Physician/surgeon fees	**20%** Coinsurance	**40%** Coinsurance	--------none--------
If you need immediate medical attention	Emergency room services	**$250** Copay/Visit	**$250** Copay/Visit	If admitted, ER Copay is waived.
	Emergency medical transportation	**20%** Coinsurance	**20%** Coinsurance	--------none--------
	Urgent care	**$35** Copay/Visit	**40%** Coinsurance	There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
If you have a hospital stay	Facility fee (e.g., hospital room)	**20%** Coinsurance	**40%** Coinsurance	--------none--------
	Physician/surgeon fee	**20%** Coinsurance	**40%** Coinsurance	--------none--------

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 **$20** Copay/Visit Mental/Behavioral Health Facility Visit – Facility Charges **20%** Coinsurance	Mental/Behavioral Health Office Visit **40%** Coinsurance Mental/Behavioral Health Facility Visit – Facility Charges **40%** Coinsurance	Mental/Behavioral Health Office Visit Costs may vary by site of service. You should refer to your formal contract of coverage for details. Mental/Behavioral Health Facility Visit- Facility Charges --------none--------
	Mental/Behavioral health inpatient services	**20%** Coinsurance	**40%** Coinsurance	--------none--------
	Substance use disorder outpatient services	Substance Abuse Office Visit **$20** Copay/Visit Substance Abuse Facility Visit – Facility Charges **20%** Coinsurance	Substance Abuse Office Visit **40%** Coinsurance Substance Abuse Facility Visit – Facility Charges **40%** Coinsurance	Substance Abuse Office Visit Costs may vary by site of service. You should refer to your formal contract of coverage for details. Substance Abuse Facility Visit - Facility Charges --------none--------
	Substance use disorder inpatient services	**20%** Coinsurance	**40%** Coinsurance	--------none--------
If you are pregnant	Prenatal and postnatal care	**20%** Coinsurance	**40%** Coinsurance	There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation.
	Delivery and all inpatient services	**20%** Coinsurance	**40%** Coinsurance	--------none--------