**Summary of Benefits and Coverage:** What this **Plan** Covers & What You Pay For Covered Services **Coverage Period: 07/01/2018– 06/30/2019**

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| **DePauw University: Blue Access for Health Savings Accounts** |  **Coverage for:** Individual + Family | **Plan Type: CDHP** |

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| image2 | **The Summary of Benefits and Coverage (SBC) document will help you choose a health** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)**. The SBC shows you how you and the** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **would share the cost for covered health care services. NOTE: Information about the cost of this** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **(called the** [[**premium**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)**) 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/aso>. For general definitions of common terms, such as [[allowed amount](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[balance billing](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[coinsurance](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[copayment](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[deductible](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[provider](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), or other underlined terms see the Glossary. You can view the Glossary at [[www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/)](http://www.healthcare.gov/sbc-glossary/) or call (833) 571-0831 to request a copy. |

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| **Important Questions** | **Answers** | **Why This Matters:** |
| **What is the overall deductible?** | **$2,000**/single or **$4,000**/family for Network Providers. **$4,000**/single or **$8,000**/family for Non-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 policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care for Network Providers.  | 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/>](https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$4,000**/single or **$6,850**/family for Network Providers. **$8,000**/single or **$16,000**/family for Non-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, the overall family out-of-pocket limit must be met. |
| **What is not included in the out-of-pocket limit?** | Non-Network Transplant Services, Premiums, balance-billing 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. |
| **Will you pay less if you use a network provider?** | Yes, Blue Access. See [www.anthem.com](http://www.anthem.com) or call (833) 571-0831 for a list of network providers. | 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 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.  |

| image3 | All [[**copayment**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) and [[**coinsurance**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) costs shown in this chart are after your [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) has been met, if a [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) applies. |
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| **Common** **Medical Event** | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information** |
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| **Network Provider****(You will pay the least)** | **Non-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 | 20% coinsurance | 40% coinsurance | --------none-------- |
| Specialist visit | 20% coinsurance | 40% coinsurance | --------none-------- |
| Preventive care**/**screening**/**immunization | No charge | 40% coinsurance | 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) | 20% coinsurance | 40% coinsurance | --------none-------- |
| Imaging (CT/PET scans, MRIs)  | 20% coinsurance | 40% coinsurance | --------none-------- |
| **If you need drugs to treat your illness or condition**More information about **prescription drug coverage** is available at <http://www.anthem.com/pharmacyinformation/>National | Tier 1 - Typically Generic | 0% coinsurance (retail) and 0% coinsurance (home delivery) | 40% coinsurance (retail) | \*See Prescription Drug section |
| Tier 2 - Typically Preferred / Brand | 40% coinsurance (retail) and 40% coinsurance (home delivery) | 40% coinsurance (retail) |
| Tier 3 - Typically Non-Preferred / Specialty Drugs | 50% coinsurance (retail) and 50% coinsurance (home delivery) | 40% coinsurance (retail) |
| Tier 4 - Typically Specialty (brand and generic) | Not Applicable | Not Applicable |
| **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 care | 20% coinsurance | Covered as In-Network | --------none-------- |
| Emergency medical transportation | 20% coinsurance | Covered as In-Network | --------none-------- |
| Urgent care | 20% coinsurance | 40% coinsurance | --------none-------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | --------none-------- |
| Physician/surgeon fees | 20% coinsurance | 40% coinsurance | --------none-------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit20% coinsuranceOther Outpatient20% coinsurance | Office Visit40% coinsuranceOther Outpatient40% coinsurance | Office Visit--------none--------Other Outpatient--------none-------- |
| Inpatient services | 20% coinsurance | 40% coinsurance | --------none-------- |
| **If you are pregnant** | Office visits | 20% coinsurance | 40% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance |
| Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | 100 visits/benefit period. |
| Rehabilitation services | 20% coinsurance | 40% coinsurance | \*See Therapy Services section |
| Habilitation services | 20% coinsurance | 40% coinsurance |
| Skilled nursing care | 20% coinsurance | 40% coinsurance | 60 days limit/benefit period. |
| Durable medical equipment | 20% coinsurance | 40% coinsurance | \*See Durable Medical Equipment Section |
| Hospice services | 0% coinsurance | 0% coinsurance | --------none-------- |
| **If your child needs dental or eye care** | Children’s eye exam | Not covered | Not covered | \*See Vision Services section |
| Children’s glasses | Not covered | Not covered |
| Children’s dental check-up | Not covered | Not covered | \*See Dental Services section |

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| **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**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/).**)** |
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| * Abortion
 | * Acupuncture
 | * Bariatric surgery
 |
| * Cosmetic surgery
 | * Dental care (adult)
 | * Dental Check-up
 |
| * Eye exams for a child
 | * Glasses for a child
 | * Hearing aids
 |
| * Infertility treatment
 | * Long- term care
 | * Routine eye care (adult)
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| * Routine foot care unless you have been diagnosed with diabetes.
 | * Weight loss programs
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| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)**  |
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| * Chiropractic care 60 visits/benefit period.
 | * Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
 | * Private-duty nursing 82 visits/benefit period. 164 visits/lifetime.
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**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: Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) for a denial of a [[claim](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/). 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 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 105568, Atlanta GA 30348-5568

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

**Does this plan provide Minimum Essential Coverage? Yes**

If you don’t have MinimumEssentialCoverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes/No**

If your plan doesn’t meet the MinimumValueStandards, you may be eligible for a premiumtaxcredit 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:**

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| image4 | **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. |

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| **Peg is Having a Baby**(9 months of in-network pre-natal care and a hospital delivery) |  | **Managing Joe’s type 2 Diabetes**(a year of routine in-network care of a well- controlled condition) |  | **Mia’s Simple Fracture**(in-network emergency room visit and follow up care) |
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|  **The** [[**plan’s**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **overall** [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)  | **$2,000** |  |  **The** [[**plan’s**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **overall** [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)  | **$2,000** |  |  **The** [[**plan’s**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **overall** [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)  | **$2,000** |
|  [[**Specialist**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) ***coinsurance*** | **20%** |  |  [[**Specialist**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) ***coinsurance*** | **20%** |  |  [[**Specialist**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) ***coinsurance*** | **20%** |
|  **Hospital (facility) *coinsurance*** | **20%** |  |  **Hospital (facility) *coinsurance*** | **20%** |  |  **Hospital (facility) *coinsurance*** | **20%** |
|  **Other** ***coinsurance*** | **20%** |  |  **Other** ***coinsurance*** | **20%** |  |  **Other** ***coinsurance*** | **20%** |
| **This EXAMPLE event includes services like:** **Specialist** office visits (*prenatal care)*Childbirth/Delivery Professional ServicesChildbirth/Delivery Facility Services**Diagnostic tests** (*ultrasounds and blood work)***Specialist** visit *(anesthesia)* |  | **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)*  |  | **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** | **$12,800** |  | **Total Example Cost** | **$7,400** |  | **Total Example Cost** | **$1,900** |
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| **In this example, Peg would pay:**  |  |  | **In this example, Joe would pay:**  |  |  | **In this example, Mia would pay:**  |  |
| ***Cost Sharing*** |  | ***Cost Sharing*** |  | ***Cost Sharing*** |
| **Deductibles** | $2,000 |  | **Deductibles** | $2,000 |  | **Deductibles** | $1,500 |
| **Copayments** | $0 |  | **Copayments** | $0 |  | **Copayments** | $0 |
| **Coinsurance** | $2,000 |  | **Coinsurance** | $2,000 |  | **Coinsurance** | $400 |
| *What isn’t covered* |  | *What isn’t covered* |  | *What isn’t covered* |
| Limits or exclusions | $60 |  | Limits or exclusions | $60 |  | Limits or exclusions | $0 |
| **The total Peg would pay is** | **$4,060** |  | **The total Joe would pay is** | **$4,060** |  | **The total Mia would pay is** | **$1,900** |

**Summary of Benefits and Coverage:** What this **Plan** Covers & What You Pay For Covered Services **Coverage Period: 07/01/2018– 06/30/2019**

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| **DePauw University: Blue Access (PPO)** |  **Coverage for:** Individual + Family | **Plan Type: PPO** |

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| image2 | **The Summary of Benefits and Coverage (SBC) document will help you choose a health** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)**. The SBC shows you how you and the** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **would share the cost for covered health care services. NOTE: Information about the cost of this** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **(called the** [[**premium**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)**) 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/aso>. For general definitions of common terms, such as [[allowed amount](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[balance billing](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[coinsurance](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[copayment](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[deductible](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[provider](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), or other underlined terms see the Glossary. You can view the Glossary at [[www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/)](http://www.healthcare.gov/sbc-glossary/) or call (833) 571-0831 to request a copy. |

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| **Important Questions** | **Answers** | **Why This Matters:** |
| **What is the overall deductible?** | **$1,000**/single or **$3,000**/family for Network Providers. **$2,000**/single or **$4,000**/family for Non-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. Preventive care, Primary Care visit, and Specialist visit for Network Providers.  | 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/>](https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$3,000**/single or **$6,000**/family for Network Providers. **$6,000**/single or **$12,000**/family for Non-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?** | Non-Network Transplant Services, Premiums, balance-billing 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. |
| **Will you pay less if you use a network provider?** | Yes, Blue Access. See [www.anthem.com](http://www.anthem.com) or call (833) 571-0831 for a list of network providers. | 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 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.  |

| image3 | All [[**copayment**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) and [[**coinsurance**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) costs shown in this chart are after your [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) has been met, if a [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) applies. |
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| **Common** **Medical Event** | **Services You May Need** | **What You Will Pay** | **Limitations, Exceptions, & Other Important Information** |
| --- | --- | --- | --- |
| **Network Provider****(You will pay the least)** | **Non-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 | $25/visit deductible does not apply | 40% coinsurance | --------none-------- |
| Specialist visit | $50/visit deductible does not apply | 40% coinsurance | --------none-------- |
| Preventive care**/**screening**/**immunization | No charge | 40% coinsurance | 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) | 20% coinsurance | 40% coinsurance | --------none-------- |
| Imaging (CT/PET scans, MRIs)  | 20% coinsurance | 40% coinsurance | --------none-------- |
| **If you need drugs to treat your illness or condition**More information about **prescription drug coverage** is available at <http://www.anthem.com/pharmacyinformation/>National | Tier 1 - Typically Generic | $10/prescription deductible does not apply (retail) and $20/prescription deductible does not apply (home delivery) | 40% coinsurance (retail) | \*See Prescription Drug section |
| Tier 2 - Typically Preferred / Brand | 30% coinsurance up to $40 maximum /prescription (retail) and 30% coinsurance up to $80 maximum /prescription (home delivery) | 40% coinsurance (retail) |
| Tier 3 - Typically Non-Preferred / Specialty Drugs | 55% coinsurance up to $55 maximum /prescription (retail) and 55% coinsurance up to $110 maximum /prescription (home delivery) | 40% coinsurance (retail) |
| Tier 4 - Typically Specialty (brand and generic) | Not Applicable | Not Applicable |
| **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 care | $200/visit deductible does not apply | Covered as In-Network | Copay waived if admitted.  |
| Emergency medical transportation | 20% coinsurance | Covered as In-Network | --------none-------- |
| Urgent care | $100/visit deductible does not apply | 40% coinsurance | --------none-------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | --------none-------- |
| Physician/surgeon fees | 20% coinsurance | 40% coinsurance | --------none-------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit$25/visit deductible does not applyOther Outpatient20% coinsurance | Office Visit40% coinsuranceOther Outpatient40% coinsurance | Office Visit--------none--------Other Outpatient--------none-------- |
| Inpatient services | 20% coinsurance | 40% coinsurance | --------none-------- |
| **If you are pregnant** | Office visits | 20% coinsurance | 40% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance |
| Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | 100 visits/benefit period. |
| Rehabilitation services | $50/visit deductible does not apply | 40% coinsurance | \*See Therapy Services section |
| Habilitation services | $25/visit deductible does not apply | 40% coinsurance |
| Skilled nursing care | 20% coinsurance | 40% coinsurance | 60 days limit/benefit period. |
| Durable medical equipment | 20% coinsurance | 40% coinsurance | \*See Durable Medical Equipment Section |
| Hospice services | No charge | No charge | --------none-------- |
| **If your child needs dental or eye care** | Children’s eye exam | Not covered | Not covered | \*See Vision Services section |
| Children’s glasses | Not covered | Not covered |
| Children’s dental check-up | Not covered | Not covered | \*See Dental Services section |

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| **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**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/).**)** |
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| * Abortion
 | * Acupuncture
 | * Bariatric surgery
 |
| * Cosmetic surgery
 | * Dental care (adult)
 | * Dental Check-up
 |
| * Eye exams for a child
 | * Glasses for a child
 | * Hearing aids
 |
| * Infertility treatment
 | * Long- term care
 | * Routine eye care (adult)
 |
| * Routine foot care unless you have been diagnosed with diabetes.
 | * Weight loss programs
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| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)**  |
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| --- | --- | --- |
| * Chiropractic care 60 visits/benefit period.
 | * Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
 | * Private-duty nursing 82 visits/benefit period. 164 visits/lifetime.
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**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: Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) for a denial of a [[claim](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/). 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 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 105568, Atlanta GA 30348-5568

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

**Does this plan provide Minimum Essential Coverage? Yes**

If you don’t have MinimumEssentialCoverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes/No**

If your plan doesn’t meet the MinimumValueStandards, you may be eligible for a premiumtaxcredit 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:**

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| --- | --- |
| image4 | **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. |

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| --- | --- | --- | --- | --- |
| **Peg is Having a Baby**(9 months of in-network pre-natal care and a hospital delivery) |  | **Managing Joe’s type 2 Diabetes**(a year of routine in-network care of a well- controlled condition) |  | **Mia’s Simple Fracture**(in-network emergency room visit and follow up care) |
|  |  |  |  |  |  |  |  |
|  **The** [[**plan’s**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **overall** [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)  | **$1,000** |  |  **The** [[**plan’s**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **overall** [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)  | **$1,000** |  |  **The** [[**plan’s**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **overall** [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)  | **$1,000** |
|  [[**Specialist**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) ***copayment*** | **$50** |  |  [[**Specialist**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) ***copayment*** | **$50** |  |  [[**Specialist**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) ***copayment*** | **$50** |
|  **Hospital (facility) *coinsurance*** | **20%** |  |  **Hospital (facility) *coinsurance*** | **20%** |  |  **Hospital (facility) *coinsurance*** | **20%** |
|  **Other** ***coinsurance*** | **20%** |  |  **Other** ***coinsurance*** | **20%** |  |  **Other** ***coinsurance*** | **20%** |
| **This EXAMPLE event includes services like:** **Specialist** office visits (*prenatal care)*Childbirth/Delivery Professional ServicesChildbirth/Delivery Facility Services**Diagnostic tests** (*ultrasounds and blood work)***Specialist** visit *(anesthesia)* |  | **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)*  |  | **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** | **$12,800** |  | **Total Example Cost** | **$7,400** |  | **Total Example Cost** | **$1,900** |
|  |  |  |  |  |  |  |
| **In this example, Peg would pay:**  |  |  | **In this example, Joe would pay:**  |  |  | **In this example, Mia would pay:**  |  |
| ***Cost Sharing*** |  | ***Cost Sharing*** |  | ***Cost Sharing*** |
| **Deductibles** | $1,000 |  | **Deductibles** | $1,000 |  | **Deductibles** | $700 |
| **Copayments** | $0 |  | **Copayments** | $600 |  | **Copayments** | $1,000 |
| **Coinsurance** | $2,000 |  | **Coinsurance** | $1,400 |  | **Coinsurance** | $200 |
| *What isn’t covered* |  | *What isn’t covered* |  | *What isn’t covered* |
| Limits or exclusions | $60 |  | Limits or exclusions | $60 |  | Limits or exclusions | $0 |
| **The total Peg would pay is** | **$3,060** |  | **The total Joe would pay is** | **$3,060** |  | **The total Mia would pay is** | **$1,900** |

**It’s important we treat you fairly**

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at [<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf). Complaint forms are available at [<http://www.hhs.gov/ocr/office/file/index.html>](http://www.hhs.gov/ocr/office/file/index.html).