



**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> by calling 1-800-582-6941.

| Important Questions                                       | Answers  | Why this Matters:  |
|---|--|--|
| What is the overall <u>deductible</u> ?                   | For in-network providers AND out-of-network providers combined:<br><b>\$3,000</b> Individual/ <b>\$6,000</b> Family<br>Deductible does not apply to: preventive care or annual vision exam. <b>Services not subject to deductible are noted in Limitations &amp; Exceptions.</b> | You must pay all the costs up to the <u>deductible</u> 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 <u>deductible</u> . |
| Are there other <u>deductibles</u> for specific services? | No.  | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.   |
| Is there an <u>out-of-pocket limit</u> on my expenses?    | In-network providers:<br><b>\$4,000</b> Individual/ <b>\$8,000</b> Family<br>Out-of-network providers:<br><b>\$6,000</b> Individual/ <b>\$12,000</b> Family  | The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (one plan 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 <u>out-of-pocket limit</u> ?  | Routine vision care, the cost of care when the benefit limits have been reached, the cost of non-covered services and amounts above the allowed amount for services.   | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |
| 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 <i>specific</i> covered services, such as office visits.   |

**Questions:** Call 1-800-582-6941 or visit us at [www.anthem.com](http://www.anthem.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.anthem.com](http://www.anthem.com) or call 1-800-582-6941 to request a copy.

# Pittsylvania County & Schools:HDHP w/HSA \$3,000/100% Coverage Period: 10/01/2016 – 09/30/2017

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

Coverage for: Individual/Family | Plan Type: HSA

|  |  |   |
|--|--|---|
| Does this plan use a <b>network of providers</b> ? | Yes. For a list of <b>providers</b> , see <a href="http://www.anthem.com">www.anthem.com</a> or call 1-800-582-6941. | If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> . |
| Do I need a referral to see a <b>specialist</b> ?  | No.  | You can see the <b>specialist</b> 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 <b>excluded services</b> .   |



- **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 **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 <b>provider's</b> office or clinic | Primary care visit to treat an injury or illness | 0% Coinsurance                              | 20% Coinsurance                                 | —————none—————   |
|   | Specialist visit                                 | 0% Coinsurance                              | 20% Coinsurance                                 |  |
|   | Other practitioner office visit                  | 0% Coinsurance for chiropractors            | 20% Coinsurance                                 | Spinal manipulations and other manual medical interventions are limited to 30 visits per member per calendar year, combined for in- and out-of-network services. |
|   | Preventive care/screening/immunization           | No Charge                                   | 20% Coinsurance                                 | Deductible does not apply when using in-network providers.   |
| If you have a test  | Diagnostic test (x-ray, blood work)              | 0% Coinsurance                              | 20% Coinsurance                                 | —————none—————   |

**Questions:** Call 1-800-582-6941 or visit us at [www.anthem.com](http://www.anthem.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.anthem.com](http://www.anthem.com) or call 1-800-582-6941 to request a copy.

# Pittsylvania County & Schools:HDHP w/HSA \$3,000/100% Coverage Period: 10/01/2016 – 09/30/2017

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

Coverage for: Individual/Family | Plan Type: HSA

| 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   |
|---|------------------------------|---|--|--|
|   | Imaging (CT/PET scans, MRIs) | 0% Coinsurance  | 20% Coinsurance  | Pre-authorization required.  |
| <p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <u>prescription drug coverage</u> is available at <a href="http://www.anthem.com">www.anthem.com</a></p> | Tier 1                       | \$10 copay/<br>prescription for Retail<br>\$25 copay /<br>prescription for Mail order | \$10 copay/<br>prescription for Retail<br>\$25 copay /<br>prescription for Mail order* | Retail pharmacy drugs are limited to a 30-day or 90- day supply. You incur additional expense for retail fills that exceed 30 days.  |
|   | Tier 2                       | \$30 copay/<br>prescription for Retail<br>\$75 copay /<br>prescription for Mail order | \$30 copay/<br>prescription for Retail<br>\$75 copay /<br>prescription for Mail order* | If you visit an out-of-network pharmacy, you will pay the full cost of your prescription at the pharmacy then file a claim for reimbursement. Reimbursement will be based on what a participating pharmacy would receive had the prescription been filled at a participating pharmacy. |
|   | Tier 3                       | \$50 copay / Retail<br>\$125 prescription /<br>Mail order                             | \$50 copay / Retail<br>\$125 prescription /<br>Mail order*                             | <b>You may also be subject to any costs above the allowed amount.*</b>   |
|   | Tier 4                       | 20% Coinsurance**   | n/a**  | Your plan uses a preferred drug list of covered drugs. Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements. If the necessary pre-authorization is not obtained, the drug may not be                                 |

**Questions:** Call 1-800-582-6941 or visit us at [www.anthem.com](http://www.anthem.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.anthem.com](http://www.anthem.com) or call 1-800-582-6941 to request a copy.

# Pittsylvania County & Schools:HDHP w/HSA \$3,000/100% Coverage Period: 10/01/2016 – 09/30/2017

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

Coverage for: Individual/Family | Plan Type: HSA

| 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  |
|---|--|---|---|---|
|   | Preventive Plus Rx                             | \$0 deductible, \$0 copay, 0% coinsurance   | n/a   | covered.<br><br>**Specialty medications must be purchased through Accredo Specialty Pharmacy. Specialty medications are limited to a 30 day fill with the exception of HIV/AIDS and transplant medications. |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center) | 0% Coinsurance                              | 20% Coinsurance                                 | —————none—————  |
|   | Physician/surgeon fees                         | 0% Coinsurance                              | 20% Coinsurance                                 | —————none—————  |
| <b>If you need immediate medical attention</b>                                | Emergency room services                        | 0% Coinsurance                              | 20% Coinsurance                                 | —————none—————  |
|   | Emergency medical transportation               | 0% Coinsurance                              | 20% Coinsurance                                 | —————none—————  |
|   | Urgent care                                    | 0% Coinsurance                              | 20% Coinsurance                                 | —————none—————  |
| <b>If you have a hospital stay</b>  | Facility fee (e.g., hospital room)             | 0% Coinsurance                              | 20% Coinsurance                                 | Pre-certification is required.  |
|   | Physician/surgeon fee                          | 0% Coinsurance                              | 20% Coinsurance                                 | —————none—————  |
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services   | 0% Coinsurance                              | 20% Coinsurance                                 | —————none—————  |
|   | Mental/Behavioral health inpatient services    | 0% Coinsurance                              | 20% Coinsurance                                 | Pre-certification is required.  |
|   | Substance use disorder outpatient services     | 0% Coinsurance                              | 20% Coinsurance                                 | —————none—————  |
|   | Substance use disorder inpatient services      | 0% Coinsurance                              | 20% Coinsurance                                 | Pre-certification is required.  |
| <b>If you are pregnant</b>  | Prenatal and postnatal care                    | 0% Coinsurance                              | 20% Coinsurance                                 | —————none—————  |
|   | Delivery and all inpatient services            | 0% Coinsurance                              | 20% Coinsurance                                 | —————none—————  |

**Questions:** Call 1-800-582-6941 or visit us at [www.anthem.com](http://www.anthem.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.anthem.com](http://www.anthem.com) or call 1-800-582-6941 to request a copy.

# Pittsylvania County & Schools:HDHP w/HSA \$3,000/100% Coverage Period: 10/01/2016 – 09/30/2017

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

Coverage for: Individual/Family | Plan Type: HSA

| 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  |
|---|---------------------------|---|---|---|
| <b>If you need help recovering or have other special health needs</b> | Home health care          | 0% Coinsurance                              | 20% Coinsurance                                 | Limited to 100 visits per calendar year. Combined in and out-of-network.  |
|   | Rehabilitation services   | 0% Coinsurance                              | 20% Coinsurance                                 | 30 combined visits for physical therapy and occupational therapy per member per calendar year combined for in- and out-of-network care. 30 visits for speech therapy per member per calendar year combined for in- and out-of-network care. |
|   | Habilitation services     | 0% Coinsurance                              | 20% Coinsurance                                 | —————none—————  |
|   | Skilled nursing care      | 0% Coinsurance                              | 20% Coinsurance                                 | 100 day per stay limit. Pre-authorization required.   |
|   | Durable medical equipment | 0% Coinsurance                              | 20% Coinsurance                                 | —————none—————  |
|   | Hospice service           | 0% Coinsurance                              | 20% Coinsurance                                 | —————none—————  |
| <b>If your child needs dental or eye care</b>                         | Eye exam                  | \$15 Copay/ visit                           | \$30 allowance/ visit                           | Deductible does not apply. One eye exam per member per calendar year.   |
|   | Glasses                   | Not covered                                 | Not covered                                     | —————none—————  |
|   | Dental check-up           | Not covered                                 | Not covered                                     | —————none—————  |

**Questions:** Call 1-800-582-6941 or visit us at [www.anthem.com](http://www.anthem.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.anthem.com](http://www.anthem.com) or call 1-800-582-6941 to request a copy.

## 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
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery
- Infertility treatment
- Routine foot care
- Dental care
- Long-term care
- Morbid obesity

### 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
- Autism Spectrum Disorder
- Home private duty nursing

## 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.

This policy has exclusions, limitations, reduction of benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call your insurance agent or Anthem.

For more information on your rights to continue coverage, contact the Plan at 540-586-1803. 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](http://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](http://www.cciio.cms.gov).

**Questions:** Call 1-800-582-6941 or visit us at [www.anthem.com](http://www.anthem.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.anthem.com](http://www.anthem.com) or call 1-800-582-6941 to request a copy.

### 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.**

### 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 30344-5568

For additional assistance regarding appeals you may contact the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### 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 adoolwoł únizínigo t'áá diné k'éjúgo, t'áá shoodí ba na'aln'íhí ya sidáhí bich'í naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aalagú bich'í hodiilní. Hai'daq iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bí'ki si'niilígú bí'kéhgo bich'í hodiilní.

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

**Questions:** Call 1-800-582-6941 or visit us at [www.anthem.com](http://www.anthem.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.anthem.com](http://www.anthem.com) or call 1-800-582-6941 to request a copy.

## 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 \$4,375
- Patient pays \$3,165

#### 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           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$3,000        |
| Copays               | \$15           |
| Coinsurance          | \$0            |
| Limits or exclusions | \$150          |
| <b>Total</b>         | <b>\$3,165</b> |

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

- Amount owed to providers: \$5,400
- Plan pays \$2,020
- Patient pays \$3,380

#### 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          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$3,000        |
| Copays               | \$300          |
| Coinsurance          | \$0            |
| Limits or exclusions | \$80           |
| <b>Total</b>         | <b>\$3,380</b> |

**Questions:** Call 1-800-582-6941 or visit us at [www.anthem.com](http://www.anthem.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.anthem.com](http://www.anthem.com) or call 1-800-582-6941 to request a copy.

## 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.

**Questions:** Call 1-800-582-6941 or visit us at [www.anthem.com](http://www.anthem.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.anthem.com](http://www.anthem.com) or call 1-800-582-6941 to request a copy.