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 1-855-634-3383.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
</table>
| What is the overall **deductible**? | **$250** Individual/$**500** Family for UK Facilities.  
**$500** Individual/$**1,000** Family for In-Network Providers.  
**$1,500** Individual/$**3,000** Family for Out-of-Network Providers.  
UK Facilities and In-Network Provider deductibles are combined. Satisfying one helps satisfy the other.  
Out-of-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 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. |

**Questions:** Call 1-855-634-3383 or visit us at 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 or call 1-855-634-3383 to request a copy.
### Is there an out-of-pocket limit on my expenses?

Yes. **$2,500** Individual/*$5,000*

Family for UK Facilities.

**$2,750** Individual/*$5,500*

Family for In-Network Providers.

**$7,500** Individual/*$15,000*

Family for Out-of-Network Providers.

UK Facilities and In-Network Provider out-of-pocket are combined. Satisfying one helps satisfy the other. Out-of-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?

Prescription Copay and Coinsurance, Penalties for failure to obtain pre-authorization, 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 3 describes any limits on what the plan will pay for specified covered services, such as office visits.

### Does this plan use a network of providers?

Yes. See [www.uky.edu/hr/benefits/OE](http://www.uky.edu/hr/benefits/OE) or call 1-855-634-3383 for a list of In-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 3 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 9. See your policy or plan document for additional information about excluded services.
### University of Kentucky: UK-PPO Plan

**Coverage Period:** 07/01/2014 - 06/30/2015

**Coverage for:** Individual/Family | **Plan Type:** PPO

---

- **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.

---

<table>
<thead>
<tr>
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<th>Services You May Need</th>
<th>Your Cost If You Use an UK Facility</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$15 Copay/Visit</td>
<td>$25 Copay/Visit</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$40 Copay/Visit</td>
<td>$50 Copay/Visit</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Specialist visit</td>
<td>Manipulative Therapy $50 Copay/Visit Acupuncturist $40 Copay/Visit</td>
<td>Manipulative Therapy $50 Copay/Visit Acupuncturist $50 Copay/Visit</td>
<td>Manipulative Therapy 50% Coinsurance Acupuncturist $50 Copay/Visit</td>
<td>Manipulative Therapy Coverage limited to 20 visits per benefit year. Acupuncturist Coverage limited to 45 visits per benefit year combined with Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive and Hydro Therapy.</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>No Cost Share</td>
<td>No Cost Share</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Cost Share</td>
<td>No Cost Share</td>
<td>50% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
</tbody>
</table>

---

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</thead>
<tbody>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab – Office 10% Coinsurance</td>
<td>Lab – Office 20% Coinsurance</td>
<td>Lab – Office 50% Coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Lab – Office 10% Coinsurance</td>
<td>Lab – Office 20% Coinsurance</td>
<td>Lab – Office 50% Coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred/Formulary Brand</td>
<td></td>
<td></td>
<td></td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-preferred/Non-formulary Drugs</td>
<td></td>
<td></td>
<td></td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Typically Specialty Drugs</td>
<td></td>
<td></td>
<td></td>
<td>---none---</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$100 Copay/Visit then 20% Coinsurance</td>
<td>$100 Copay/Visit then 20% Coinsurance</td>
<td>$100 Copay/Visit then 20% Coinsurance</td>
<td>If admitted, the ER Copay is waived.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 Copay/Visit</td>
<td>$50 Copay/Visit</td>
<td>50% Coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>---none---</td>
</tr>
</tbody>
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<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>Mental/Behavioral Health Office Visit $15 Copay/Visit Mental/Behavioral Health Facility Visit – Facility Charges 10% Coinsurance</td>
<td>Mental/Behavioral Health Office Visit $25 Copay/Visit Mental/Behavioral Health Facility Visit – Facility Charges 20% Coinsurance</td>
<td>Mental/Behavioral Health Office Visit 50% Coinsurance Mental/Behavioral Health Facility Visit – Facility Charges 50% Coinsurance</td>
<td>Mental/Behavioral Health Office Visit 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. Mental/Behavioral Health Facility Visit – Facility Charges none</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health inpatient services</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>Residential Treatment is Not Covered.</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Substance abuse disorder outpatient services</td>
<td>Substance Abuse Office Visit $15 Copay/Visit Substance Abuse Facility Visit – Facility Charges 10% Coinsurance</td>
<td>Substance Abuse Office Visit $25 Copay/Visit Substance Abuse Facility Visit – Facility Charges 20% Coinsurance</td>
<td>Substance Abuse Office Visit 50% Coinsurance Substance Abuse Facility Visit – Facility Charges 50% Coinsurance</td>
<td>Substance Abuse Office Visit 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. Substance Abuse Facility Visit – Facility Charges none</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Substance abuse disorder inpatient services</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>Residential Treatment is Not Covered.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>none</td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>Delivery and all inpatient services</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>Applies to inpatient facility. Other cost shares may apply depending on the services provided.</td>
<td></td>
</tr>
</tbody>
</table>

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<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>Coverage is limited to 100 visits per benefit year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$20 Copay/Visit</td>
<td>$30 Copay/Visit</td>
<td>50% Coinsurance</td>
<td>Coverage limited to 45 visits per benefit year for Physical Therapy, Occupational Therapy, Speech Therapy, Cognitive and Hydro Therapy combined with Acupuncture.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$20 Copay/Visit</td>
<td>$30 Copay/Visit</td>
<td>50% Coinsurance</td>
<td>Habilitation visits count towards your Rehabilitation limit.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>Coverage is limited to 100 days per benefit year combined In-Network and Out-of-Network Providers.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% Coinsurance</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>Coverage is limited to one per benefit year and no maximum for Wigs.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>10% Coinsurance</td>
<td>20% Coinsurance</td>
<td>50% Coinsurance</td>
<td>---none---</td>
</tr>
</tbody>
</table>
### Common Medical Event

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<th>Your Cost If You Use an In-Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye exam</td>
<td>$15 Copay/Visit</td>
<td>$25 Copay/Visit</td>
<td>50% Coinsurance</td>
<td>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. Coverage is for medical Vision exam only. You should refer to your formal contract of coverage for details.</td>
</tr>
<tr>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Refer to your Vision plan benefits.</td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Refer to your Dental plan benefits.</td>
</tr>
</tbody>
</table>

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Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (Unless you have been diagnosed with diabetes. Consult your formal contract of coverage.)
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (Coverage is limited to one per ear every 36 months under age 18.)
- 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 1-855-634-3383. 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.

Questions: Call 1-855-634-3383 or visit us at www.anthem.com.
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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 Blue Shield
ATTN: Appeals
P.O. Box 105568
Atlanta, GA 30348-5568

Department of Insurance
215 West Main Street
Frankfort, Kentucky 40601
Main: 502-564-3630
Toll Free (Kentucky only): 800-595-6053
TTY: 800-648-6056

Or Contact:

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

A consumer assistance program can help you file your appeal. Contact:

Kentucky Department of Insurance
Consumer Protection Division
P.O. Box 517

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 regalamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是会员並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已参保，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’ilügo eei dooda’i, shikáa adoolwoł ñinizinigoo t’áá diné k’èjúgo, t’áá shoodi ba na’alnihí ya sidáhí bich’i naabídú’likid. Ei doo biigha daago ni ba’nija’go ho’aalagii bich’i hodilní. Hai’dáa imi’taago eïya, t’áá shoodi diné ya atah halne’gií ni béésh bee hane’i wólta’ bi’ki si’niligii bi’kéhgo bich’i hodilní.

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

Questions: Call 1-855-634-3383 or visit us at www.anthem.com.
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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.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $6,420</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $1,120</td>
</tr>
</tbody>
</table>

**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 $250
- Copays $0
- Coinsurance $710
- Limits or exclusions $150

**Total** $1,110

<table>
<thead>
<tr>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $1,850</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $3,550</td>
</tr>
</tbody>
</table>

**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 $250
- Copays $150
- Coinsurance $790
- Limits or exclusions $80

**Total** $1,270

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.

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Questions and answers about the Coverage Examples:

What 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 1-855-634-3383 or visit us at 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 or call 1-855-634-3383 to request a copy.