The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) 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, visit http://www.thelocalchoice.virginia.gov/planinfo/employeeplans.html. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-888-642-4414 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500**/person or **$1,000**/family for in-network providers. **$1,000**/person or **$2,000**/family for out-of-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 services, in-network care including office visits, and routine vision.	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.
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**/person or **$8,000**/family for in-network provider. **$7,000**/person or **$14,000**/family for out-of-network provider.	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?	Dental, routine vision, **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**.
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call 1-800-552-2682 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

* For more information about limitations and exceptions, see the **plan** or policy document at www.thelocalchoice.virginia.gov.

Important Questions	Answers	Why This Matters:
		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.**

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-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	30% **coinsurance** after **deductible**	**Balance billing** may occur for out-of-network services.
	Specialist visit	$40/visit	30% **coinsurance** after **deductible**	**Balance billing** may occur for out-of-network services.
	Preventive care/**screening**/immunization	No charge	30% **coinsurance** after **deductible**	**Balance billing** may occur for out-of-network services.
If you have a test	**Diagnostic test** (x-ray, blood work)	20% **coinsurance** after **deductible**	30% **coinsurance** after **deductible**	**Balance billing** may occur for out-of-network services.
	Imaging (CT/PET scans, MRIs)	20% **coinsurance** after **deductible**	30% **coinsurance** after **deductible**	**Balance billing** may occur for out-of-network services.
If you need drugs to treat your illness or condition More information about	Typically Generic drugs (Tier 1)	$10/**copay** (retail); $20/**copay** (home delivery)	$10/**copay** (retail); $20/**copay** (home delivery)	Retail up to 34 day supply; home delivery up to 90 day supply. Mandatory generic program. If you or your doctor requests a brand named drug when a generic is available, you pay the brand **copay** plus the difference between the allowable
	Typically Preferred / Brand drugs (Tier 2)	$30/**copay** (retail); $60/**copay** (home delivery)	$30/**copay** (retail); $60/**copay** (home delivery)	

* For more information about limitations and exceptions, see the **plan** or policy document at www.thelocalchoice.virginia.gov.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
prescription drug coverage is available at anthem.com/tlc	Typically Non-Preferred / **Specialty drugs** (Tier 3)	$45/**copay** (retail); $90/**copay** (home delivery)	$45/**copay** (retail); $90/**copay** (home delivery)	charge for the generic and the brand named drug. **Balance billing** may occur for out-of-network services.
	Typically **Specialty drugs** (Tier 4)	$55/**copay** (retail); $110/**copay** (home delivery)	$55/**copay** (retail); $110/**copay** (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance** after **deductible**	30% **coinsurance** after **deductible**	**Balance billing** may occur for out-of-network services.
	Physician/surgeon fees	$25 PCP; $40 Specialist/visit	30% **coinsurance** after **deductible**	**Balance billing** may occur for out-of-network services.
If you need immediate medical attention	**Emergency room care**	20% **coinsurance** after **deductible**	Covered as In-Network	Copay waived if admitted. **Balance billing** may occur for out-of-network services.
	Emergency medical transportation	20% **coinsurance** after **deductible**	Covered as In-Network	**Balance billing** may occur for out-of-network services.
	Urgent care	$25 PCP; $40 Specialist/visit	30% **coinsurance** after **deductible**	**Balance billing** may occur for out-of-network services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance** after **deductible**	30% **coinsurance** after **deductible**	**Balance billing** may occur for out-of-network services.
	Physician/surgeon fee	No charge	30% **coinsurance** after **deductible**	**Balance billing** may occur for out-of-network services.
If you need mental health, behavioral health, or substance abuse needs	Outpatient services	Office Visit $25/visit Other Outpatient 20% **coinsurance** after **deductible**	30% **coinsurance** after **deductible**	**Balance billing** may occur for out-of-network services. Employee Assistance Program (EAP) covered at no charge with up to 4 visits per incident per **plan** year.
	Inpatient services	20% **coinsurance** after **deductible**	30% **coinsurance** after **deductible**	

* For more information about limitations and exceptions, see the **plan** or policy document at www.thelocalchoice.virginia.gov.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$25 PCP; $40 Specialist/visit	30% coinsurance after deductible	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Balance billing may occur for out-of-network services.
	Childbirth/delivery professional services	No charge	30% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	30% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance after deductible	90 visits/benefit period. Balance billing may occur for out-of-network services.
	Rehabilitation services	20% coinsurance after deductible	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
	Habilitation services	20% coinsurance after deductible	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
	Skilled nursing care	No charge	30% coinsurance after deductible	180 day/benefit period. Balance billing may occur for out-of-network services.
	Durable medical equipment	20% coinsurance after deductible	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
	Hospice service	No charge	30% coinsurance after deductible	Balance billing may occur for out-of-network services.
If your child needs dental or eye care	Eye exam	$40 copay	Balance after $50	Limit one exam per plan year under the age of 19.
	Glasses	$20 copay for lenses; balance over $100 for frames	Balance after $50 for single lenses; balance over $80 for frames	--------none--------
	Dental check-up	No charge	Covered as in-network	Balance billing may occur for out-of-network services.

* For more information about limitations and exceptions, see the plan or policy document at www.thelocalchoice.virginia.gov.

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
- Infertility treatment
- Weight loss programs
- Cosmetic surgery
- Long-term care
- Hearing aids (adult)
- Routine foot care unless you have been diagnosed with diabetes

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (In-Network)
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Chiropractic care (In-Network)
- Private-duty nursing (In-Network)
- Routine eye care (In-Network)
- Dental care (adult) - diagnostic and preventive only (In-Network)

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 or call 1-800-318-2596.

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: Director, Department of Human Resource Management, 101 North 14th Street – 12th Floor, Richmond, Virginia 23219-3657. Mark envelope Confidential-Appeal Enclosed. Telephone: 1-888-642-4414.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have **Minimum Essential Coverage** 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

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** 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:

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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$90
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,650**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$980
Coinsurance	$370
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,910**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$120
Coinsurance	$320
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$940**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-642-4414.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document

Spanish
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու
ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf