Henry County & Schools

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

Coverage Period: 07/01/2017 – 06/30/2018

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

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com or by calling 1-800-445-7490.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$0**/Individual; **$0**/Family Out-of-network: **$500** Individual; **$1,000**/Family	You must pay all the costs up to the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see chart on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network providers: **$3,000** Individual **/** **$6,000** Family Out-of-network providers: **$4,500** Individual **/** **$9,000** Family **Prescription drugs: $3,500** Individual/**$7,200** Family calendar year limit per person on out-of-pocket expenses for prescription drugs	The **out-of-pocket limit** is the most you could pay during a coverage period (one calendar 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?	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 **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Questions: Call 1-800-445-7490 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 1-800-445-7490 to request a copy.

Does this plan use a network of providers?	Yes. For a list of participating medical providers, see www.anthem.com or call 1-800-445-7490.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You 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 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the
- **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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	30% coinsurance	——————none——————
	Specialist visit	$40 copay/visit	30% coinsurance	——————none——————
	Other practitioner office visit	$20 PCP/$40 specialist copay/visit	30% coinsurance	Spinal manipulation and manual medical therapy limited to 30 visits per calendar year.
	Preventive care/screening/immunization	No charge	30% coinsurance	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.anthem.com.	Tier 1	$10 copay/ prescription for 30 day supply $10 copay/ prescription for 90 day supply	$10 copay/ prescription for 30 day supply $10 copay/ prescription for 90 day supply*	Retail and Specialty Drugs (tier 4) covers up to a 30 day supply. Mail order and Retail Maintenance covers up to a 90 day supply. 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. ***You may also be subject to any costs above the allowed amount.** Your plan uses a preferred drug list (formulary) which identifies the status of covered drugs. Some drugs may require preauthorization, while other drugs are subject to step therapy and quantity limit requirements. If the necessary preauthorization is not obtained, the drug may not be covered.
	Tier 2	$30 copay/ prescription for 30 day supply $60 copay/ Prescription for 90 day supply	$30 copay/ prescription for 30 day supply $60 copay/ Prescription for 90 day supply*	
	Tier 3	$50 copay/ prescription for 30 day supply $150 copay/ Prescription for 90 day supply	$50 copay/ prescription for 30 day supply $150 copay/ Prescription for 90 day supply*	
	Tier 4	20% coinsurance per prescription for 30 day supply ($200 per prescription max) 20% coinsurance per prescription for 90 day supply ($400 per prescription max)	Not applicable	

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay plus 20% coinsurance	30% coinsurance	———none———
	Physician/surgeon fees	$20 PCP/$40 specialist copay/ visit	30% coinsurance	———none———
If you need immediate medical attention	Emergency room services	$200 copay plus 20% coinsurance	30% coinsurance	———none———
	Emergency medical transportation	$150 copay/ transport	30% coinsurance	———none———
	Urgent care	$20 PCP/$40 specialist copay/ visit	30% coinsurance	———none———
If you have a hospital stay	Facility fee (e.g., hospital room)	$400 copay plus 20% coinsurance	30% coinsurance	———none———
	Physician/surgeon fee	20% coinsurance	30% coinsurance	———none———

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**Outpatient office setting**: $20 copay/ visit **Outpatient facility setting**: 20% coinsurance	30% coinsurance	———none———
	Mental/Behavioral health inpatient services	$400 copay plus 20% coinsurance	30% coinsurance	Precertification required.
	Substance use disorder outpatient services	**Outpatient office setting**: $20 copay/ visit **Outpatient facility setting**: 20% coinsurance	30% coinsurance	———none———
	Substance use disorder inpatient services	$400 copay plus 20% coinsurance	30% coinsurance	Precertification required.
If you are pregnant	Prenatal and postnatal care	$200 copay	30% coinsurance	———none———
	Delivery and all inpatient services	$400 copay plus 20% coinsurance	30% coinsurance	———none———

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	100 visit limit per calendar year.
	Rehabilitation services	$20 PCP/ $40 specialist or facility copay/office visit	30% coinsurance	30 combined visits for physical therapy and occupational therapy; 30 visits for speech therapy.
	Habilitation services	$20 PCP/ $40 specialist or facility copay/office visit	30% coinsurance	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	20% coinsurance	30% coinsurance	100 day per stay limit; preauthorization required.
	Durable medical equipment	20% coinsurance	30% coinsurance	———————none———————
	Hospice service	No charge	30% coinsurance	———————none———————
If your child needs dental or eye care	Eye exam	Not covered	Not Covered	———————none———————
	Glasses	Not covered	Not Covered	———————none———————
	Dental check-up	Not covered	Not Covered	———————none———————

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
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-care
- Morbid obesity
- Routine foot care
- Routine eye care

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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
- Private-duty nursing
- Autism Spectrum Disorder

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 276-634-4708. 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.

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: Appeals, Attention Member Services, P.O. Box 27401, Richmond, VA 23279.

You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-EBSA (3272) or www.dol/ebsa/healthreform.

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.**

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

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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.

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** $6,630
- **Patient pays** $910

Sample care costs:

Item	Cost
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:

Item	Cost
Deductibles	$0
Copays	$620
Coinsurance	$140
Limits or exclusions	$150
Total	**$910**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,440
- **Patient pays** $960

Sample care costs:

Item	Cost
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:

Item	Cost
Deductibles	$0
Copays	$600
Coinsurance	$280
Limits or exclusions	$80
Total	**$960**

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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.

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Language Access Services/KeyCare:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (800) 451-1527

Amharic (አማርኛ)፦ ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 451-1527 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (800) 451-1527.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (800) 451-1527:

Bassa (Ɓǎsɔ́ɔ̀ Wùɖù): M̀ dyi dyi-diè-ɖɛ̀ ɓě ɓéɖé ɓá céè-ɖɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-ɓɛ̀ɖɛ̀in-ɖɛ̀ ɓɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ ɖé m̀ ɓíɖí-wùɖùǔn ɓó pídyi. Ɓɛ́ m̀ ké wuɖu-zìin-nyɔ̀ ɖò gbo wùɖù kɛ, ɖá (800) 451-1527.

Bengali (বাংলা): যদি এই তথ্য পুস্তিকার বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য কল করুন (800) 451-1527

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (800) 451-1527 သို့ ခေါ်ဆိုပါ။

Chinese (中文)： 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (800) 451-1527。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (800) 451-1527.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (800) 451-1527.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (800) 451-1527 تماس بگیرید.

Language Access Services/KeyCare:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (800) 451-1527.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (800) 451-1527.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (800) 451-1527.

Gujarati (ગુજરાતી): જો આ દસતાવજ અંગવ આપનવ કોઈપણ ��નો હોય તો, કોઈપણ ખચર ગર આપની ભાષામાં મદદ અનવ માહિતી મવળ ાનો તમનવ અધિકાર છવ. દુભાષિયા સાથવ ાત કર ા માટવ, કોલ કરો (800) 451-1527.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (800) 451-1527 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (800) 451-1527.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (800) 451-1527.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (800) 451-1527.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (800) 451-1527.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (800) 451-1527

Language Access Services/KeyCare:

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(800) 451-1527 にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (800) 451-1527 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (800) 451-1527.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (800) 451-1527 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (800) 451-1527.

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bááh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (800) 451-1527.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा नि:शुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ। दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (800) 451-1527

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Language Access Services/KeyCare:

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (800) 451-1527 ਤੇ ਕਾਲ ਕਰੋ।

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Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (800) 451-1527.

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Yoruba (Yoruba): Ti o ba ni eylkeyil ibere nipa aKQSl1yil, o ni tQ lati gba iranwQ ati iwiftln ni ede!ylQf. Ba wa ogbllfQ kan SQ!Qpe (800) 451-1527.

Anthem BCBS Virginia

Henry County 2017/2018 Employee Semi-Monthly Rates

Employee Only	= $ 0
Employee & 1 Child	= $271.67
Employee & Children	= $357.82
Employee & Spouse	= $368.44
Employee & Family	= $624.48