

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Graftech International Holdings, Inc-Anthem Blue Access PPO HSA with National Rx - National w/R90 with Optional Home Delivery

Your Network: Blue Access

Effective: January 01, 2021

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$3,000 person / \$6,000 family	\$6,000 person / \$12,000 family
Out-of-Pocket Limit	\$6,000 person / \$12,000 family	\$12,000 person / \$24,000 family
<p>The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.</p>		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after deductible is met
<u>Doctor Home and Office Services</u>		
Primary Care Visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care Visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prenatal and Post-natal Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Practitioner Visits:</u>		
Retail Health Clinic	20% coinsurance after deductible is met	40% coinsurance after deductible is met
On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy <i>Coverage is limited to 20 visits per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Services in an Office:</u> Allergy Testing Chemo/Radiation Therapy Dialysis/Hemodialysis Prescription Drugs - <i>Dispensed in the office</i>	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab: Office Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
X-Ray: Office Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
Advanced Diagnostic Imaging: Office Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Emergency and Urgent Care</u> Urgent Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
<u>Ambulance</u>	20% coinsurance after deductible is met	Covered as In-Network
<u>Outpatient Mental/Behavioral Health and Substance Abuse</u> Doctor Office Visit Facility Visit: Facility Fees Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees: Hospital Doctor and Other Services: Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u> Facility Fees Human Organ and Tissue Transplants	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><i>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i></p> <p>Doctor and other services</p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 120 visits per benefit period. Limits are combined for all home health services.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Rehabilitation services:</p> <p>Office <i>Coverage is a combined 60 visits for Occupational Therapy, Physical Therapy and Speech Therapy per benefit period. Limit is combined for rehabilitative and habilitative services.</i></p> <p>Office <i>Coverage is a combined 60 visits for Occupational Therapy, Physical Therapy and Speech Therapy per benefit period. Limit is combined for rehabilitative and habilitative services.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Cardiac rehabilitation</p> <p>Office <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage is limited to 36 visits per benefit period.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 120 days combined per benefit period.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Hospice</p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Durable Medical Equipment</p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Prosthetic Devices</p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical	Combined with medical
Prescription Drug Coverage <i>National with R90</i> <i>National Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.</i>		
Tier 1 - Typically Generic <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	20% coinsurance after deductible is met (retail and home delivery)	Not Covered
Tier 2 – Typically Preferred Brand <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	35% coinsurance after deductible is met (retail and home delivery)	Not Covered
Tier 3 - Typically Non-Preferred Brand <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	50% coinsurance after deductible is met (retail and home delivery)	Not Covered

Notes:

- Benefit Period: Calendar Year
- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details,

important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Your Plan: Graftech International Holdings, Inc-Anthem Blue Access PPO HSA

Your Network: Blue Access

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable) <i>Dennis M. Robinson</i>	Date October 28, 2020
Underwriting signature (if applicable)	Date

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Questions: (833) 639-1634 or visit us at www.anthem.com

OH/LG/Graftech International Holdings, Inc-Anthem Blue Access PPO HSA Option E5//01-01-2021

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Curious to know what all this says? We would be too. Here's the English version:

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(TTY/TDD: 711)

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Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 639-1634.

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Language Access Services:

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Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 639-1634.

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