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, https://eoc.anthem.com/eocdps/aso. 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 (855) 255-9952 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100**/single or **$200**/family for Network Providers. **$300**/single or **$600**/family for Non-Network Providers.	Deductible resets January 1. 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 care, Primary Care visit, Specialist visit, and Vision exam for Network Providers.	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?	**$1,000**/single or **$2,000**/family for Network Providers. **$2,000**/single or **$4,000**/family for Non-Network Providers. Prescription drugs have a separate limit of **$3,000** single/ **$6,000** family In-network & out-of-network combined.	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?	Services deemed not medically necessary by Medical Management and/or Anthem, Premiums, balance-billing 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	Yes, Blue Card PPO. See www.anthem.com or call (855)	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

provider?	255-9952 for a list of network providers.	a bill from a provider for the difference between the provider's charge and what 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)	Non-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 deductible does not apply	30% coinsurance	--------none--------
	Specialist visit	$25/visit deductible does not apply	30% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Tier 1 - Typically Generic	Retail: $10 copay Mail-Order: $10 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30-day supply Mail-Order: Up to a 60-day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Notification requirement or may result in a higher cost. If you use a non-network Pharmacy, you are responsible for any amount over the allowed amount. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 Contraceptives covered at No Charge.
	Tier 2 - Typically Preferred / Brand	Retail: $20 copay Mail-Order: $20 copay	Not Covered	
	Tier 3 - Typically Non-Preferred / Specialty Drugs	Retail: $30 copay Mail-Order: $30 copay	Not Covered	
	Tier 4 - Typically Specialty (brand and generic)	Retail: 30% coinsurance, deductible does not apply OR $0 with PrudentRx Mail-Order: Not Covered	Not Covered	

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				See the website listed for information on drugs covered by your plan. Not all drugs are covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	10% coinsurance	30% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	$150/visit deductible does not apply	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	No Charge	Covered as In-Network	--------none--------
	Urgent care	$50/visit deductible does not apply	Covered as In-Network	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	--------none--------
	Physician/surgeon fees	10% coinsurance	30% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $25/visit deductible does not apply Other Outpatient 10% coinsurance	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	10% coinsurance	30% coinsurance	--------none--------
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	90 visits/benefit period non-network
	Rehabilitation services	$25/visit deductible does not apply	30% coinsurance	*See Therapy Services section
	Habilitation services	$25/visit deductible does not apply	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	180 days limit/benefit period.
	Durable medical equipment	10% coinsurance	30% coinsurance	*See Durable Medical Equipment Section
	Hospice services	No Charge	Covered as In-Network	--------none--------

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$25/visit deductible does not apply	30% coinsurance	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion
- Cosmetic surgery
- Glasses for a child
- Routine foot care unless you have been diagnosed with diabetes.
- Acupuncture
- Dental care (adult)
- Infertility treatment
- Weight loss programs
- Bariatric surgery
- Dental Check-up
- Long- term care

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

- Chiropractic care 12 visits/benefit period.
- Private-duty nursing only covered in the Home.
- Hearing aids 1/ear every 3 years. $2,500 maximum/benefit period.
- Routine eye care (adult) 1/benefit period.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

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, 1-877-267-2323 x61565, 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: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso.

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.

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/aso.

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	$100
Specialist *copayment*	$25
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$10
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,070**

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

The plan's overall deductible	$100
Specialist *copayment*	$25
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$600
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$800**

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

The plan's overall deductible	$100
Specialist *copayment*	$25
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$300
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$430**

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

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.