



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/](http://www.healthcare.gov/sbc-glossary/) or call (855) 255-9952 to request a copy.

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| What is the overall <a href="#">deductible</a> ?                                | \$2,000/individual contract or \$4,000/family contract for In- <a href="#">Network Providers</a> .<br>\$4,000/individual contract or \$8,000/family contract for Out-of- <a href="#">Network Providers</a> .  | Deductible resets January 1. Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay. Deductible is non-embedded.   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> for In- <a href="#">Network Providers</a> .  | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| Are there other <a href="#">deductibles</a> for specific services?              | No.   | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$4,000/individual contract or \$8,000/family contract for In- <a href="#">Network Providers</a> .<br>\$8,000/individual contract or \$16,000/family contract for Out-of- <a href="#">Network Providers</a> . | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Services deemed not medically necessary by Medical Management and/or Anthem, <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.     | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes, Blue Card PPO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (855) 255-9952 for a list of <a href="#">network</a>   | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a>   |

|  |                             |  |
|--|-----------------------------|--|
|  | <a href="#">providers</a> . | pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b> | No.                         | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .   |



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   |
|---|---|---|--|--|
|   |   | In-Network Provider<br>(You will pay the least)                                     | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>   | Primary care visit to treat an injury or illness                                    | 10% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>                    | -----none-----   |
|   | <a href="#">Specialist</a> visit  | 10% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>                    | -----none-----   |
|   | <a href="#">Preventive care</a> / <a href="#">screening</a> /immunization           | No charge   | 30% <a href="#">coinsurance</a>                    | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.  |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)                                 | 10% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>                    | -----none-----   |
|   | Imaging (CT/PET scans, MRIs)  | 10% <a href="#">coinsurance</a>   | 30% <a href="#">coinsurance</a>                    | -----none-----   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> | Tier 1 - Typically Generic  | Retail: \$10 copay after deductible;<br>Home Delivery: \$20 copay after deductible  | Not covered  | Provider means pharmacy for purposes of this section.<br>Retail: Up to a 30-day supply<br>Mail-Order: Up to a 90-day supply<br>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<br>Contraceptives covered at No Charge. See the website listed for information |
|   | Tier 2 - Typically <a href="#">Preferred</a> / Brand                                | Retail: \$40 copay after deductible;<br>Home Delivery: \$80 copay after deductible  | Not covered  |  |
|   | Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a> | Retail: \$60 copay after deductible;<br>Home Delivery: \$120 copay after deductible | Not covered  |  |
|   | Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)                    | Not Applicable  | 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  |
|---|--|---|---|---|
|   |  | In-Network Provider<br>(You will pay the least)     | Out-of-Network Provider<br>(You will pay the most)  |   |
|   |  |   |   | on drugs covered by your plan. Not all drugs are covered.                                       |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)   | 10% <a href="#">coinsurance</a>                     | 30% <a href="#">coinsurance</a>                     | -----none-----  |
|   | Physician/surgeon fees                           | 10% <a href="#">coinsurance</a>                     | 30% <a href="#">coinsurance</a>                     | -----none-----  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 10% <a href="#">coinsurance</a>                     | Covered as In- <a href="#">Network</a>              | -----none-----  |
|   | <a href="#">Emergency medical transportation</a> | 10% <a href="#">coinsurance</a>                     | Covered as In- <a href="#">Network</a>              | -----none-----  |
|   | <a href="#">Urgent care</a>                      | 10% <a href="#">coinsurance</a>                     | 30% <a href="#">coinsurance</a>                     | -----none-----  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 10% <a href="#">coinsurance</a>                     | 30% <a href="#">coinsurance</a>                     | -----none-----  |
|   | Physician/surgeon fees                           | 10% <a href="#">coinsurance</a>                     | 30% <a href="#">coinsurance</a>                     | -----none-----  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office Visit<br>10% <a href="#">coinsurance</a>     | Office Visit<br>30% <a href="#">coinsurance</a>     | Office Visit<br>-----none-----  |
|   |  | Other Outpatient<br>10% <a href="#">coinsurance</a> | Other Outpatient<br>30% <a href="#">coinsurance</a> | Other Outpatient<br>-----none-----  |
|   | Inpatient services                               | 10% <a href="#">coinsurance</a>                     | 30% <a href="#">coinsurance</a>                     | -----none-----  |
| If you are pregnant   | Office visits                                    | 10% <a href="#">coinsurance</a>                     | 30% <a href="#">coinsurance</a>                     | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|   | Childbirth/delivery professional services        | 10% <a href="#">coinsurance</a>                     | 30% <a href="#">coinsurance</a>                     |   |
|   | Childbirth/delivery facility services            | 10% <a href="#">coinsurance</a>                     | 30% <a href="#">coinsurance</a>                     |   |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 10% <a href="#">coinsurance</a>                     | 30% <a href="#">coinsurance</a>                     | 90 visits/benefit period Non-Network providers.   |
|   | <a href="#">Rehabilitation services</a>          | 10% <a href="#">coinsurance</a>                     | 30% <a href="#">coinsurance</a>                     | *See Therapy Services section   |
|   | <a href="#">Habilitation services</a>            | 10% <a href="#">coinsurance</a>                     | 30% <a href="#">coinsurance</a>                     |   |
|   | <a href="#">Skilled nursing care</a>             | 10% <a href="#">coinsurance</a>                     | 30% <a href="#">coinsurance</a>                     | 180 days limit/benefit period.  |
|   | <a href="#">Durable medical equipment</a>        | 10% <a href="#">coinsurance</a>                     | 30% <a href="#">coinsurance</a>                     | *See <a href="#">Durable Medical Equipment</a> Section  |
|   | <a href="#">Hospice services</a>                 | 10% <a href="#">coinsurance</a>                     | Covered as In- <a href="#">Network</a>              | -----none-----  |
| If your child needs dental or eye care                                    | Children's eye exam                              | 10% <a href="#">coinsurance</a>                     | 30% <a href="#">coinsurance</a>                     | *See Vision Services section  |
|   | Children's glasses                               | Not covered   | Not covered   |   |
|   | Children's dental check-up                       | Not covered   | Not covered   | *See Dental Services section  |

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

## 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](#).)

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

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

- |  |   |   |
|--|---|---|
| • Abortion   | • Chiropractic care 12 visits/benefit period.   | • Hearing aids 1/ear every 3 years. \$2,500 maximum/benefit period. |
| • Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a> | • Private-duty nursing 82 visits/benefit period. 164 visits/lifetime. 90 visits/benefit period including <a href="#">home health care</a> . | • Routine eye care (adult)  |

**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](http://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](http://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](http://www.cciio.cms.gov)**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](#) \$2,000
- [Specialist coinsurance](#) 10%
- 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: |          |
| <a href="#">Cost Sharing</a>    |          |
| <a href="#">Deductibles</a>     | \$2,000  |
| <a href="#">Copayments</a>      | \$10     |
| <a href="#">Coinsurance</a>     | \$1,100  |
| <i>What isn't covered</i>       |          |
| Limits or exclusions            | \$60     |
| The total Peg would pay is      | \$3,170  |

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist coinsurance](#) 10%
- 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: |         |
| <a href="#">Cost Sharing</a>    |         |
| <a href="#">Deductibles</a>     | \$2,000 |
| <a href="#">Copayments</a>      | \$500   |
| <a href="#">Coinsurance</a>     | \$100   |
| <i>What isn't covered</i>       |         |
| Limits or exclusions            | \$20    |
| The total Joe would pay is      | \$2,620 |

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist coinsurance](#) 10%
- 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: |         |
| <a href="#">Cost Sharing</a>    |         |
| <a href="#">Deductibles</a>     | \$2,000 |
| <a href="#">Copayments</a>      | \$0     |
| <a href="#">Coinsurance</a>     | \$80    |
| <i>What isn't covered</i>       |         |
| Limits or exclusions            | \$0     |
| The total Mia would pay is      | \$2,080 |

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>.