




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 ?	\$1,000/individual or \$2,000/family for In- Network Providers and Out-of- Network Providers combined. The HRA account reimburses you for certain deductible amounts up to \$700/individual contract or \$1,400/family contract.	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 In- 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 ?	\$5,000/individual or \$10,000/family for In- Network Providers . \$5,000/individual or \$10,000/family for Out-of- Network Providers .	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, Non- Network Human Organ and Tissue Transplant (HOTT) Services, 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 provider?	Yes, Blue Card PPO. See www.anthem.com or call (855) 255-9952 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 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
		In-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	20% coinsurance	40% coinsurance	-----none-----
	Specialist visit	20% coinsurance	40% coinsurance	-----none-----
	Preventive care / screening /immunization	No charge	40% 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)	20% coinsurance	40% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% 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: \$20 copay	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30-day supply Mail-Order: Up to a 90-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. See
	Tier 2 - Typically Preferred / Brand	Retail: \$25 copay Mail-Order: \$50 copay	Not Covered	
	Tier 3 - Typically Non- Preferred / Specialty Drugs	Retail: \$40 copay Mail-Order: \$80 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				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)	20% coinsurance	40% coinsurance	-----none-----
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	20% coinsurance	Covered as In- Network	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	Covered as In- Network	-----none-----
	Urgent care	20% coinsurance	Covered as In- Network	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	-----none-----
	Physician/surgeon fees	20% coinsurance	40% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 20% coinsurance	Office Visit 40% coinsurance	Office Visit -----none-----
		Other Outpatient 20% coinsurance	Other Outpatient 40% coinsurance	Other Outpatient -----none-----
	Inpatient services	20% coinsurance	40% coinsurance	-----none-----
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	100 visits/benefit period.
	Rehabilitation services	20% coinsurance	40% coinsurance	*See Therapy Services section
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	100 days limit/benefit period.
	Durable medical equipment	20% coinsurance	40% coinsurance	*See Durable Medical Equipment Section
	Hospice services	20% coinsurance	Covered as In- Network	-----none-----
If your child needs dental or eye care	Children's eye exam	20% coinsurance	40% 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

* 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](#).)

- | | | |
|-----------------------|---|-------------------------|
| • Abortion | • Bariatric surgery | • Cosmetic surgery |
| • Dental care (adult) | • Dental Check-up | • Infertility treatment |
| • Long- term care | • Routine foot care unless you have been diagnosed with diabetes. | • Weight loss program |

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

- | | | |
|--|--|---|
| • Acupuncture | • 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 www.bcbsglobalcore.com | • Private-duty nursing only covered in the Home. 82 visits/benefit period. | • 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. 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

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	\$1,000
■ Specialist copayment	20%
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$40
Coinsurance	\$2,520
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,620

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	20%
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$635
Coinsurance	\$585
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,275

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	20%
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$385
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,385

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>.