




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:
<b>What is the overall deductible?</b>	<b>\$100</b> /individual or <b>\$200</b> /family for In- <b>Network Providers</b> . <b>\$200</b> /individual or <b>\$400</b> /family for Out-of- <b>Network Providers</b> .	Deductible resets January 1. Generally, you must pay all of the costs from <b>providers</b> up to the <b>deductible</b> amount before this <b>plan</b> begins to pay. If you have other family members on the <b>plan</b> , each family member must meet their own individual <b>deductible</b> until the total amount of <b>deductible</b> expenses paid by all family members meets the overall family <b>deductible</b> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Primary Care visit, <b>Specialist</b> visit, and Vision exam for In- <b>Network Providers</b> . <b>Preventive care</b> for In- <b>Network</b> and Out-of- <b>Network Providers</b> .	This <b>plan</b> covers some items and services even if you haven't yet met the <b>deductible</b> amount. But a <b>copayment</b> or <b>coinsurance</b> may apply. For example, this <b>plan</b> covers certain preventive services without <b>cost-sharing</b> and before you meet your <b>deductible</b> . 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> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<b>\$1,000</b> /individual or <b>\$2,000</b> /family for In- <b>Network Providers</b> . <b>\$2,000</b> /individual or <b>\$4,000</b> /family for Out-of- <b>Network Providers</b> . Prescription drugs have a separate limit of <b>\$3,000</b> individual/ <b>\$6,000</b> family In-network & out-of-network combined.	The <b>out-of-pocket limit</b> is the most you could pay in a year for covered services. If you have other family members in this <b>plan</b> , they have to meet their own <b>out-of-pocket limits</b> until the overall family <b>out-of-pocket limit</b> has been met.
<b>What is not included in the out-of-pocket limit?</b>	Services deemed not medically necessary by Medical Management and/or Anthem, Prescription drug costs, Penalties for non-compliance, Non- <b>Network</b> Transplant Services, <b>Premiums</b> , <b>balance-billing</b> charges, and health care this <b>plan</b> doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .

<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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 providers</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> 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30/visit <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	\$50/visit <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	No charge	20% <a href="#">coinsurance</a>	Hearing exam (routine): Not covered. Vision exam (routine): 30% <a href="#">coinsurance</a> for Out-of- <a href="#">Network Providers</a> . One/benefit period. 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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	20% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	No charge	20% <a href="#">coinsurance</a>	-----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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> 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 Mail-Order: \$20 copay	Retail: 50% co-ins Minimum \$30 Mail-Order: 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 website listed for information on drugs covered by your plan. Not all drugs are covered.
	Tier 2 - Typically <a href="#">Preferred</a> / Brand	Retail: \$20 copay Mail-Order: \$40 copay	Retail: 50% co-ins Minimum \$30 Mail-Order: Not covered	
	Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a>	Retail: \$30 copay Mail-Order: \$60 copay	Retail: 50% co-ins Minimum \$30 Mail-Order: Not covered	
	Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)	Not covered	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	-----none-----
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100/visit <a href="#">deductible</a> does not apply	Covered as In- <a href="#">Network</a>	Copay waived if admitted.
	<a href="#">Emergency medical transportation</a>	No charge	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	\$50/visit <a href="#">deductible</a> does not apply	Covered as In- <a href="#">Network</a>	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	20% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	No charge	20% <a href="#">coinsurance</a>	-----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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Office Visit & Other Outpatient 20% <a href="#">coinsurance</a>	-----none-----
	Inpatient services	No charge	20% <a href="#">coinsurance</a>	-----none-----
If you are pregnant	Office visits	\$30/visit <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No charge	20% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	20% <a href="#">coinsurance</a>	90 visits/calendar year for combined network & Out-of- <a href="#">Network Providers</a> .
	<a href="#">Rehabilitation services</a>	\$30-\$50/visit <a href="#">deductible</a> does not apply	20% <a href="#">coinsurance</a>	Therapy visits are per calendar year. All visit limits are combined network & non-network. All rehabilitation & habilitation visits count toward your rehabilitation visit limit.
	<a href="#">Habilitation services</a>	No charge	20% <a href="#">coinsurance</a>	Speech = 20 visits PT & OT = 30 visits each
	<a href="#">Skilled nursing care</a>	No charge	20% <a href="#">coinsurance</a>	180 days limit/calendar year
	<a href="#">Durable medical equipment</a>	No charge	20% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Hospice services</a>	No charge	20% <a href="#">coinsurance</a>	-----none-----
If your child needs dental or eye care	Children's eye exam	No charge	20% <a href="#">coinsurance</a>	Preventive exam
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	-----none-----

\* 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
- Dental care (adult)
- Long-term care
- Bariatric surgery
- Hearing aids
- Routine foot care unless you have been diagnosed with diabetes.
- Cosmetic surgery
- Infertility treatment
- Weight loss programs

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

- Acupuncture
- Private-duty nursing only covered in the home.
- Chiropractic care 12 visits/benefit period.
- Routine eye care (adult)
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://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](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/No

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/No

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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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	\$12,840
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$96
<b>The total Peg would pay is</b>	<b>\$1,096</b>

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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	\$7,460
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$13
<i>What isn't covered</i>	
Limits or exclusions	\$6,041
<b>The total Joe would pay is</b>	<b>\$6,354</b>

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$100
■ <a href="#">Specialist copayment</a>	\$20
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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	\$2,010
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$86
<a href="#">Copayments</a>	\$365
<a href="#">Coinsurance</a>	\$18
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$469</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

# Language Access Services:

(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 (855) 255-9952

**Amharic (አማርኛ):** ለትኩረት ይዘት ላይ ጥያቄዎን ያቀርቡን። ለተጨማሪ መረጃ እና ለሌሎች ጥያቄዎች ወይንም ለማግኘት ለተጨማሪ መረጃ ይግኙን። (855) 255-9952 ይግኙን።

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 255-9952.

**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՝ (855) 255-9952:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè b̄é b̄édé b̄á céè-djè n̄à ke dyí ní, ɔ̀ m̄ò n̄ì dyí-b̄èd̄j̄èin-djè b̄é m̄ ké gbo-kpá-kpá kè b̄ǎ́ kp̄ǎ́ djé m̄ b̄ídj̄í-wùdùù̄n b̄ó pídyi. B̄é m̄ ké wuɖu-zìin-nyò d̄ò gbo wùdù ke, d̄á (855) 255-9952.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 255-9952 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (855) 255-9952 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您对本文件有任何疑问，您有权使用您的语言免费获得协助和资讯。如需与译员通话，请致电 (855) 255-9952。

**Dinka (Dinka):** Na n̄ɔ̄j thiëc n̄e ke de yā thorē, ke yin n̄ɔ̄j loj b̄e yi kuony ku w̄er al̄eu b̄e ḡēer yic yin ne thōj du ke cin w̄eu tā̄auē ke piny. Te k̄or yin ba jam w̄enē ran ye thok geryic, ke yin col (855) 255-9952.

**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 (855) 255-9952.

**Farsi (فارسی):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 255-9952 تماس بگیرید.

**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 (855) 255-9952.

**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 (855) 255-9952.

**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 (855) 255-9952.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ વિશે કોઈ પ્રશ્ન હોય, તો આપને આ માહિતી અને સહાયતા મેળવવાનો અધિકાર છે. અનુભવેલા અર્થઘટ્ટો (855) 255-9952 નાં નંબર પર કોલ કરવા માટે સંપર્ક કરો.

**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 (855) 255-9952.

**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 (855) 255-9952 ।

## Language Access Services:

**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 (855) 255-9952.

**Igbo (Igbo):** O bur u na i nwere ajuju o bula gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o bula. Ka gi na okowa okwu kwuo okwu, kpoo (855) 255-9952.

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