




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 . \$2,000 /individual or \$4,000 /family for Out-of- 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 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 ? | \$2,000 /individual or \$4,000 /family for In- Network Providers . \$4,000 /individual or \$8,000 /family for Out-of- 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, Non- Network Human Organ and Tissue Transplant (HOTT) Services, Premiums , balance-billing charges, and health care | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |

| | | |
|--|---|--|
| | this plan doesn't cover. | |
| 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/visit deductible does not apply | 40% coinsurance | -----none----- |
| | Specialist visit | \$20/visit deductible does not apply | 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: \$12 copay Mail-Order: \$24 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 |
| | Tier 2 - Typically Preferred / Brand | Retail: \$24 copay Mail-Order: \$48 copay | Not covered | |
| | Tier 3 - Typically Non- Preferred / Specialty Drugs | Retail: 50% (\$40 Min/\$50 Max copay) Mail-Order: \$80 copay | 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) | |
| | Tier 4 - Typically Specialty (brand and generic) | Retail: 30% coinsurance, deductible does not apply OR \$0 with PrudentRx Mail-Order: Not covered | Not covered | 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 not 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 | \$100/visit deductible does not apply | Covered as In- Network | Copay waived if admitted. |
| | Emergency medical transportation | 20% coinsurance | Covered as In- Network | -----none----- |
| | Urgent care | \$50/visit deductible does not apply | \$50/visit deductible does not apply | -----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 No charge Other Outpatient No charge | Office Visit 40% coinsurance Other Outpatient 40% coinsurance | Office Visit -----none----- 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 | 30 visits/benefit period for Out-of- Network Providers including private duty nursing. |
| | Rehabilitation services | \$20/visit deductible does not apply | 40% coinsurance | *See Therapy Services section |

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| 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) | |
| | Habilitation services | \$20/visit deductible does not apply | 40% coinsurance | 180 days limit/benefit period. *See Durable Medical Equipment Section -----none----- |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | |
| | Hospice services | 20% coinsurance | 20% coinsurance | |
| If your child needs dental or eye care | Children's eye exam | \$20/visit deductible does not apply | 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 |

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](#).)

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • Abortion • Cosmetic surgery • Routine foot care unless you have been diagnosed with diabetes. | <ul style="list-style-type: none"> • Acupuncture • Dental care (adult) • Infertility treatment • Weight loss programs | <ul style="list-style-type: none"> • 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.)

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> • Chiropractic care 12 visits/benefit period. • Routine eye care (adult) | <ul style="list-style-type: none"> • Most coverage provided outside the United States. See www.bcbsglobalcore.com | <ul style="list-style-type: none"> • Private-duty nursing only covered in the home. 30 visits/benefit period for Out-of-Network Providers including home health care. |
|---|--|--|

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.

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

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 |
|--------------------|----------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,000 |
| Copayments | \$48 |
| Coinsurance | \$1,000 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,108 |

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 |
|--------------------|---------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1000 |
| Copayments | \$884 |
| Coinsurance | \$327 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$2,312 |

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 |
|--------------------|---------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| Deductibles | \$83 |
| Copayments | \$440 |
| Coinsurance | \$21 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$544 |

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>.