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](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/](https://www.healthcare.gov/sbc-glossary/) or call (844) 422-7714 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$250/individual or $500/family for In-Network Providers, $500/individual or $1,000/family for Out-of-Network Providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care, Primary Care visit, Specialist visit, and Vision exam for In-Network Providers.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$1,750/individual or $3,500/family for In-Network Providers, $3,500/individual or $7,000/family for Out-of-Network Providers.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Services deemed not medically necessary by Medical Management and/or Anthem, Penalties for non-compliance, Non-Network Transplant Services, Premiums, balance-billing charges, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes, Blue Card PPO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (844) 422-7714 for a list of network</td>
<td>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</td>
</tr>
</tbody>
</table>
For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.

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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20/visit deductible does not apply</td>
<td>40% coinsurance</td>
<td>Hearing exam (routine) and Vision exam (routine): Not covered. 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.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30/visit deductible does not apply</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>$8/prescription (retail) and $12/prescription (home delivery)</td>
<td>$40/prescription or 50% coinsurance, whichever is greater (retail)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred/Brand</td>
<td>$25/prescription (retail) and $22/prescription or 10% coinsurance, whichever is greater (home delivery)</td>
<td>$40/prescription or 50% coinsurance, whichever is greater (retail)</td>
<td>*See Prescription Drug section</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred/Specialty Drugs</td>
<td>$40/prescription (retail) and $60/prescription or 10% coinsurance, whichever is greater (home delivery)</td>
<td>$40/prescription or 50% coinsurance, whichever is greater (retail)</td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 4 - Typically Specialty (brand and generic)</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need emergency medical attention</td>
<td>Emergency room care</td>
<td>$200/visit deductible does not apply</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$40/visit deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit deductible does not apply</td>
<td>Office Visit deductible does not apply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Outpatient 20% coinsurance</td>
<td>Other Outpatient 40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$30/visit deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Children’s eye exam</td>
<td>$20 or $30/visit deductible does not apply</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>*See Dental Services section</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

**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)
- Infertility treatment
- Weight loss programs

- Acupuncture
- Dental Check-up
- Long-term care

- Cosmetic surgery
- Glasses for a child
- Routine foot care unless you have been diagnosed with diabetes.

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

- Bariatric surgery
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Chiropractic care 12 visits/benefit period.
- Private-duty nursing 82 visits/benefit period. Only covered in the home.

- Hearing aids
- 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/No**

* For more information about limitations and exceptions, see **plan** or policy document at [https://eoc.anthem.com/eocdps/aso](https://eoc.anthem.com/eocdps/aso).
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 plan's overall deductible $250
- Specialist copayment $30
- 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** $12,840

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Peg's Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

What isn't covered

Limits or exclusions $60

The total Peg would pay is $1,810

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

- The plan’s overall deductible $250
- Specialist copayment $30
- 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** $7,460

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Joe's Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$503</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$997</td>
</tr>
</tbody>
</table>

What isn't covered

Limits or exclusions $55

The total Joe would pay is $1,805

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

- The plan’s overall deductible $250
- Specialist copayment $30
- 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** $2,010

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Mia's Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$810</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$172</td>
</tr>
</tbody>
</table>

What isn't covered

Limits or exclusions $0

The total Mia would pay is $1,232

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 (844) 422-7714.

Amharic (አማርኛ): ያቅር ወሳኝ ያለባህርምም ከተጠቀም ከአማርኛ ከነጠቀም, ማን ያቀረቡት ማንም የሚያሳይ መጋቢት ያላገኝም መታየት ከአማርኛ ከነጠቀም ያስፈላጂ. ከስፈላጊው ከአማርኛ (844) 422-7714 ይደረገል።

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկություն ձեր լեզվով։ Թարգմանչի հետ խոսելու համար զանգահարեք (844) 422-7714:

Bassa (Ɓàssɔ Wùrà): M dyi dyi-die-dë bë bëde bë cëe-dë nià ke dyì nì, c mò nì dyi-bëdëwin-dë bë m ké gbo-kpá-kpá kë bò kpö dë m bidii-wùdùun bò pìdyì. Bë m ké wùdù-ziìn-nyò dò gbo wùdù ke, dà (844) 422-7714.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও ভাষা পাওয়ার অধিকার আপনার আছে। একজন ভাষাসহকারীর সাথে কথা বলার জন্য (844) 422-7714 —তে কল করুন।

Burmese (ဗမာ): သီးသန့်စိတ်ဝင်စာရင်းသည် သိရုံးအတွက် ပါဝင်ပြီး အခြေခံသူလိုအပ်ချက်များ ဖြစ်ပေါ်သည်။ အခြေခံသူနှင့် ဆက်စပ်ရေး အတွက် မေးမြန်းပါ။ အရေးပါသူ တွေ့ရိုး ကြည့်ပါ။ (844) 422-7714 ကြည့်ပါ။

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 (844) 422-7714。

Dinka (Dinka): Na ngor thiee nê ke de yä thorë, ke yìn ngor log bë yi kyony ku wer alëu bë gëer yin ne thon du ke ciin wëw tàatu ke pìny. Te kôr yin ba jam wëné ran ye thok getyic, ke yìn col (844) 422-7714.

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 (844) 422-7714.

Farsi (فارسی): در صورتی که سوالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ مزیت‌هایی به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شффاهی، با شماره (844) 422-7714 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 (844) 422-7714.
Language Access Services:

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Ansprüche auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitten Sie (844) 422-7714.

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 (844) 422-7714.

Gujarati (ગુજરાતી): કેટલીક પ્રશ્નો દરેક પ્રદાન કરવા માટે તમારી ભાષામાં સફાઈ અને માહિતી મળી શકે છે. વાતચીત કરવા માટે કીંમત હોઈ શકે નહીં. તમારા દીક્ષિત અથવા સાથી સાથી સાથી સાથી સાથી સાથી સાથી સાથી સાથી સાથી સાથી સાથી સાથી સાથી સાથી (844) 422-7714.

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 entèprè, rele (844) 422-7714.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज के बारे में कोई प्रश्न है, तो आपको निश्चितकरण अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। कॉल करें (844) 422-7714.

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 (844) 422-7714.

Igbo (Igbo): Ọ bụrụ na ọrụ na ọwa ajụjụ ọ bụla gbasara akwụkwọ a, ọrụ na ihe iwu anya na ọzi ọ bụla. Ọ bụrụ na ọkụwa okwu kwuo okwu, kpọọ (844) 422-7714.

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Nepali (नेपाली): यदि आप कार्यालयीय हिस्ट्री फार्मेज ड्रायवर दुरुस्ती प्रश्न बनाए जाने, आपकी भाषा मान्यता सहयोग तथा जानकारी प्राप्त करने बालक तपाईं छ। दोभाषीताहरु कुरा नर्किस लागि, यहाँ कल गरुद्वार (844) 422-7714

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Language Access Services:

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