## Summary of Benefits and Coverage:

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

### Important Questions

<table>
<thead>
<tr>
<th></th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$2,000/individual or $4,000/family for In-Network Providers, $4,000/individual or $8,000/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 policy, the overall family deductible must be met before the plan begins to pay. The 2019 Affordable Care Act in-network annual out-of-pocket maximum for any individual on a qualified plan is $7,900.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care 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>What is the out-of-pocket limit for this plan?</td>
<td>$3,000/individual or $6,000/family for In-Network Providers, $6,000/individual or $12,000/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, the overall family out-of-pocket limit must be 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, 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 providers.</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 a bill from a provider for the difference between the provider’s charge and what your plan allows.</td>
</tr>
</tbody>
</table>
Do you need a referral to see a specialist?  No. You can see the specialist you choose without a referral.

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Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information
---|---|---|---
**If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 10% coinsurance (In-Network Provider) | 30% coinsurance (Out-of-Network Provider) | ----none-------
| Specialist visit | 10% coinsurance (In-Network Provider) | 30% coinsurance (Out-of-Network Provider) | ----none-------
| Preventive care/screening/immunization | No charge (In-Network Provider) | 30% coinsurance (Out-of-Network Provider) | 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) | 10% coinsurance (In-Network Provider) | 30% coinsurance (Out-of-Network Provider) | ----none-------
| Imaging (CT/PET scans, MRIs) | 10% coinsurance (In-Network Provider) | 30% coinsurance (Out-of-Network Provider) | ----none-------

**If you need drugs to treat your illness or condition** | Tier 1 - Typically Generic | 10% coinsurance (retail) and 10% coinsurance (home delivery) (In-Network Provider) | 30% coinsurance (retail) (Out-of-Network Provider) | *See Prescription Drug section
| Tier 2 - Typically Preferred/Brand | 10% coinsurance (retail) and 10% coinsurance (home delivery) (In-Network Provider) | 30% coinsurance (retail) (Out-of-Network Provider) | |
| Tier 3 - Typically Non-Preferred/ Specialty Drugs | 10% coinsurance (retail) and 10% coinsurance (home delivery) (In-Network Provider) | 30% coinsurance (retail) (Out-of-Network Provider) | |
| Tier 4 - Typically Specialty (brand and generic) | Not Applicable (In-Network Provider) | Not Applicable (Out-of-Network Provider) | |

**If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance (In-Network Provider) | 30% coinsurance (Out-of-Network Provider) | ----none-------
| Physician/surgeon fees | 10% coinsurance (In-Network Provider) | 30% coinsurance (Out-of-Network Provider) | ----none-------
| Emergency room care | 10% coinsurance (In-Network Provider) | Covered as In-Network (Out-of-Network Provider) | ----none-------

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* 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></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office Visit 10% coinsurance Other Outpatient 10% coinsurance</td>
<td>Office Visit 30% coinsurance Other Outpatient 30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>0% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>0% coinsurance</td>
<td>0% coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* 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).
### 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
- Routine foot care unless you have been diagnosed with diabetes.
- Acupuncture
- Dental Check-up
- Long-term care
- Weight loss programs
- Cosmetic surgery
- Glasses for a child
- Routine eye care (adult)

### 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 only covered in the home. 82 visits/benefit period.
- Hearing aids

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**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.

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* 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).
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 **$12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions **$60**

**The total Peg would pay is** **$3,060**

### 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 **$7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$700</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions **$60**

**The total Joe would pay is** **$2,760**

### 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 **$1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,700</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions **$0**

**The total Mia would pay is** **$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.
Language Access Services:

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 (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 (ગાજરાતી): જુઓ દુઃખ અથવા શું જોવા માંગો છો, તે સામાન્ય સંબંધમાં કે સંબંધમાં કોઈપણ સમસ્યા છો, તે તમારી ભાષામાં સામાન્ય સંબંધમાં પ્રશ્ન સમાધાન મળી શકે છે. તેથી (844) 422-7714 માટે કોલ 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 (844) 422-7714.

Hindi (हिंदी): जब आपके पास इस दस्तावेज के बारे में कोई प्रश्न है, तो आपको तिलेक्षण अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। तुम्हारे लिए फोन 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 i nwere ajụjụ ọ bula gbasara akwụkwọ a, i nwere ike ịnweta enyemaka na ọzi ịnasụ ị na akwụghị ịgwọ ọ bula. Ka gi na ọkọwa okwu kwuo okwu, kpoọ (844) 422-7714.

Ilokano (Ilokano): Nu addaan ka iti anieman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem ngaawan ti bayad na. Tapno makatungtong ti maya nga tagipatarus, awangan ti (844) 422-7714.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (844) 422-7714.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 422-7714.

Japanese (日本語): この文書について看不懂な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(844) 422-7714 にお電話ください。
Language Access Services:

Khmer (ឡាភណ៍): ពិនិត្យជាតិដ៏ល្អសម្រាប់អ្នកអ៊ីនធឺណិត ។ ការសិក្ដឹងចិត្តប្រការដំបូងការដោយអ្នកប្រឈមតាមខ្លួន។ សូមទាញឱ្យកាន់កាបូបូសម្រាប់ (844) 422-7714 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (844) 422-7714.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (844) 422-7714 로 문의하십시오.

Lao (ລາວ): ធ្វើការបានឈ្មោះត្រូវបានក្លាយជាដៃក្លាស់ប្រចាំថ្ងៃមក, តាមរយៈរបាយការណ៍ពីព្រះបាទីពីរស្តាប់ដោយសូមចូលនិយាយនៃធ្វើការដំបូង។ ដោយវាយតម្លៃការបានប្រឈមតាម (844) 422-7714.

Navajo (Dine): Díí naaltsoos biká’ígií lahgó bina’idilkidgo ná bohóneédzjá dóó bee ahót’í’ t’áá ni nizaad k’ehjí bee nił hodoonih t’áadoo bááh ilinígóó. Ata’háól’ígií la’ bich’í’ hadnéeszhíh nínizingo kojí’ hodíilnih (844) 422-7714.

Nepali (नेपाली): यदि आपको इस निर्देशांक का काम करने की आवश्यकता है, तो आपको हिंदी में अनुवाद एवं जानकारी का अधिकार है। हिंदी में अनुवाद के लिए (844) 422-7714 का नंबर पर संपर्क साबित करें।

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan kettiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (844) 422-7714 bilbilla.


Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (844) 422-7714.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (844) 422-7714.

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