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/as0](https://eoc.anthem.com/eocdps/as0). 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 (877) 814-9709 to request a copy.

### Important Questions | Answers | Why This Matters:
--- | --- | ---
What is the overall deductible? | $1,500/individual or $3,000/family. All Providers. | 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.
Are there services covered before you meet your deductible? | Yes. Preventive care for In-Network and Out-of-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/](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? | $3,000/individual or $6,000/family. All 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? | Non-Network Transplant Services, Services deemed not medically necessary by Medical Management and/or Anthem, 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, National PPO (Blue Card PPO). See [www.anthem.com](http://www.anthem.com) or call (877) 814-9709 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.
**Do you need a referral to see a specialist?**

No. You can see the specialist you choose without a referral.

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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).

---

<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>
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<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% coinsurance</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>
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<td>Specialist visit</td>
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<tr>
<td></td>
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<td>No charge</td>
<td>40% coinsurance deductible does not apply</td>
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<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
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<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
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<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1 - Typically Generic</td>
<td>$10 copay (up to 30 day supply); $20 copay (31-90 day supply)</td>
<td>Not Covered</td>
<td>Pharmacy Benefit Management Services are provided by CVS Caremark.</td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred / Brand</td>
<td>20% - minimum $30, maximum $50 (up to 30 day supply); minimum $60, maximum $100 (31-90 day supply)</td>
<td>Not Covered</td>
<td>Up to a 90 day supply is available at CVS Caremark Mail Service Pharmacy or CVS Pharmacy Locations.</td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred / Specialty Drugs</td>
<td>40% - minimum $50, maximum $70 (up to 30 day supply); minimum $100, maximum $140 (31-90 day supply)</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Typically Specialty (brand and generic)</td>
<td>40% - minimum $75, maximum $150 (30 day supply only)</td>
<td>Not covered</td>
<td></td>
</tr>
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---

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

---

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<td>Tier 4 - Typically Specialty (brand and generic)</td>
<td>40% - minimum $75, maximum $150 (30 day supply only)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>In-Network Provider (You will pay the least) 20% coinsurance 40% coinsurance</td>
<td>--none--</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Out-of-Network Provider (You will pay the most) 20% coinsurance 40% coinsurance</td>
<td>--none--</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>20% coinsurance</td>
<td>--none--</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Covered as In-Network</td>
<td>--none--</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>--none--</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>--none--</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>--none--</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>--none--</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>--none--</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>20% coinsurance Other Outpatient 20% coinsurance</td>
<td>--none--</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>--none--</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance 40% coinsurance</td>
<td>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance</td>
<td>--none--</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>--none--</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>--none--</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>*See Therapy Services section</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>100 days limit/benefit period.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>*See Durable Medical Equipment Section</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>20% coinsurance</td>
<td>--none--</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>20% coinsurance</td>
<td>*See Vision Services section</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td></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.
**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)
- Hearing aids
- Routine foot care unless you have been diagnosed with diabetes.
- Acupuncture
- Dental Check-up
- Infertility treatment
- Weight loss programs
- Cosmetic surgery
- Glasses for a child
- Long-term care

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

- Bariatric surgery
- Chiropractic care 12 visits/benefit period.
- Private-duty nursing only covered in the home. 82 visits/benefit period. 164 visits/lifetime.
- Routine eye care (adult)
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

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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. 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


**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.

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* 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
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<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td>$1,500</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Specialist coinsurance</strong></td>
<td><strong>Specialist coinsurance</strong></td>
<td><strong>Specialist coinsurance</strong></td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

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:
- **Cost Sharing**
  - Deductibles | $1,500 |
  - Copayments | $0 |
  - Coinsurance | $1,500 |
  - What isn’t covered | $96 |
  - The total Peg would pay is | $3,096 |

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:
- **Cost Sharing**
  - Deductibles | $959 |
  - Copayments | $0 |
  - Coinsurance | $240 |
  - What isn’t covered | $6,041 |
  - The total Joe would pay is | $7,239 |

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:
- **Cost Sharing**
  - Deductibles | $1,500 |
  - Copayments | $0 |
  - Coinsurance | $385 |
  - What isn’t covered | $6,041 |
  - The total Mia would pay is | $1,885 |

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 lindje me këtë dokument, keni të drejtë të merrni fals ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (877) 814-9709

Amharic (አማርኛ): ይቅ Halifax እስከ እነወ ይሁን እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታይ ከእነ ይህ እንታยว (877) 814-9709

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկություններ։ Թարգմանչի հետ խոսեք (877) 814-9709:

Bassa (Bãsɔɔ Wùdu): M dyi dyi-die-dë bë bëdë dyi-bëdë nië ke dyi ni, o më ni dyi-bëdëin-dë bë m ke gbo-kpá-kpá kë bë kpö dé m bëdį-wùduùn bó pidyi. Bë m ke wùdu-zën-nyò dopamine wùdu ke, då (877) 814-9709.

Bengali (বাংলা): যদি এই বিষয়ের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষার বিলাসুল্ল সাহায্য পাওয়ার ও ভুক্ত পাওয়ার অনিকার আপনার আদায়। একজন ডিজিটালীনির সাথে কথা বলার জন্য (877) 814-9709 -তে কল করুন।


Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (877) 814-9709。

Dinka (Dinka): Na ngi thiëec nê ke de yà thorë, ke yin ngi logbê yi kuony ku wer aleu bê geer yic yin ne thon du ke ci wëu täzë ke piny. Te kor yin ba jam wênc ran ye thok gëyic, ke yin col (877) 814-9709.

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Language Access Services:

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