




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 (844) 437-0495 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$500/individual or \$1,000/family for In- Network Providers . \$1,000/individual or \$2,000/family for Out-of- Network 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 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?	Yes; \$50 single for In-Network Providers Prescription Drug. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	\$3,000/individual or \$6,000/family for In- Network Providers . \$6,000/individual or \$12,000/family for Out-of- Network Providers . This plan has a separate out-of-pocket limit of \$4,150 for prescription drug.	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, Penalties for non-compliance, Non- Network Transplant Services, prescription drugs, Premiums , balance-billing	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

	charges, and health care 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 (844) 437-0495 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	30% coinsurance	-----none-----
	Specialist visit	\$40/visit deductible does not apply	30% coinsurance	-----none-----
	Preventive care / screening / immunization	No charge	30% 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)	Lab – Office No charge X-Ray – Office 15% coinsurance	Lab – Office 30% coinsurance X-Ray – Office 30% coinsurance	Lab – Office -----none----- X-Ray – Office -----none-----
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30% coinsurance	-----none-----
If you need drugs to treat your illness or condition	Tier 1 - Typically Generic	\$10 copay per prescription (retail only) and \$20 copay per prescription (home delivery only)	\$50 copay per prescription or 50% coinsurance, whichever is greater (retail only)	Covers up to a 30 day supply (retail) Covers up to a 90 day supply (home delivery) Prescription Drug deductible does not apply to Tier 1
	Tier 2 - Typically Preferred / Brand	\$40 copay per prescription (retail only) and \$100 copay per prescription (home delivery only)	\$50 copay per prescription or 50% coinsurance, whichever is greater (retail only)	Member may be responsible for additional cost if not selecting available generic drug for Tier 2, Tier 3 & Tier 4

* 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)	
More information about prescription drug coverage is available at www.caremark.com	Tier 3 - Typically Non- Preferred / Specialty Drugs	\$60 copay per prescription (retail only) and \$150 copay per prescription (home delivery only)	\$50 copay per prescription or 50% coinsurance, whichever is greater (retail only)	
	Tier 4 - Typically Specialty (brand and generic)	25% coinsurance up to \$200 per prescription (retail only) and 25% coinsurance up to \$200 per prescription (home delivery only)	\$50 copay per prescription or 50% coinsurance, whichever is greater (retail only)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	30% coinsurance	-----none-----
	Physician/surgeon fees	15% coinsurance	30% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	\$250/visit deductible does not apply	Covered as In- Network	Copay waived if admitted.
	Emergency medical transportation	15% coinsurance	15% coinsurance	-----none-----
	Urgent care	\$75/visit deductible does not apply	30% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	30% coinsurance	-----none-----
	Physician/surgeon fees	15% coinsurance	30% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$20/visit deductible does not apply Other Outpatient 15% coinsurance	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	15% coinsurance	30% coinsurance	-----none-----
If you are pregnant	Office visits	\$20 or \$40/visit first visit deductible does not apply then 15% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	15% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	15% coinsurance	30% coinsurance	
	Home health care	15% coinsurance	30% coinsurance	-----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 help recovering or have other special health needs	Rehabilitation services	\$20 or \$40/visit deductible does not apply	30% coinsurance	*See Therapy Services section
	Habilitation services	Costs vary by site of service	30% coinsurance	
	Skilled nursing care	15% coinsurance	30% coinsurance	90 days limit/benefit period.
	Durable medical equipment	15% coinsurance	30% coinsurance	*See Durable Medical Equipment Section .
	Hospice services	15% coinsurance	15% coinsurance	-----none-----
If your child needs dental or eye care	Children's eye exam	\$40/exam deductible does not apply	30% 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](#).)

- Abortion
- Cosmetic surgery
- Infertility treatment
- Weight loss programs
- Acupuncture
- Dental care (adult)
- Long- term care
- Bariatric surgery
- Hearing aids
- 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.)

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

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 Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. 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 Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

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	\$500
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	0%

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:

Cost Sharing	
Deductibles	\$500
Copayments	\$40
Coinsurance	\$1,728
<i>What isn't covered</i>	
Limits or exclusions	\$96
The total Peg would pay is	\$2,364

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	0%

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:

Cost Sharing	
Deductibles	\$0
Copayments	\$240
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$6,041
The total Joe would pay is	\$6,281

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	0%

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:

Cost Sharing	
Deductibles	\$500
Copayments	\$950
Coinsurance	\$129
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,579

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) 437-0495.

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) 437-0495.

Gujarati (ગુજરાતી): જો તમે આ દસ્તાવેજ વિશે કોઈ પ્રશ્ન ધરાવો છો, તો તમને મફત સહાય અને માહિતી તમારી ભાષામાં મળી શકે છે. અમારા અનુભવિત અર્થઘટ્ટકો સાથે વાત કરવા માટે, કૃપા કરીને (844) 437-0495 નો 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) 437-0495.

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 (844) 437-0495 ।

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) 437-0495.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajujụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (844) 437-0495.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (844) 437-0495.

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) 437-0495.

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) 437-0495

Japanese (日本語): この文書についてなにかご不明な点があれば、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) 437-0495 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ (844) 437-0495 ។

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) 437-0495.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (844) 437-0495 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລຳບວກວ່າມແບພາສາ, ໃຫ້ໂທຫາ (844) 437-0495.

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjĩ bee nił hodoonih t'áadoo báąh ilinígóó.
Ata' halne'ígíí la' bich'i' hadeesdzih nínízingo kojĩ' hodiilnih (844) 437-0495.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (844) 437-0495

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (844) 437-0495 bilbilla.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (844) 437-0495 aa.

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) 437-0495.

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) 437-0495.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (844) 437-0495 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (844) 437-0495.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (844) 437-0495.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totoi. Ina ia talanoa i se tagata faaliliu, vili (844) 437-0495.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (844) 437-0495.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (844) 437-0495.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (844) 437-0495.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (844) 437-0495 เพื่อพูดคุยกับล่าม

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Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (844) 437-0495 پر کال کریں۔

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