
 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) 593-8123 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible? | \$250 /individual or \$500 /family for In- 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 and Specialist visit 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. \$100 /individual or \$200 /family for 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? | \$4,000 /individual or \$8,000 /family for In- Network Providers . This plan has a separate Out of Pocket Maximum of \$1,500 /individual or \$3,000 /family for Prescription Drugs . | 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? | Prescription Drugs , Services deemed not medically necessary by Medical Management and/or Anthem, Penalties for non-compliance, 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 Blue High Performance Network (BlueHPN Non-Tiered). See www.anthem.com or call (855) 593-8123 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 | \$25/visit deductible does not apply | Not covered | -----none----- |
| | Specialist visit | \$45/visit deductible does not apply | Not covered | -----none----- |
| | Preventive care / screening /immunization | No charge | 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. |
| If you have a test | Diagnostic test (x-ray, blood work) | \$25/visit at independent lab or office, deductible does not apply; \$200 / visit at outpatient facility. | Not covered | -----none----- |
| | Imaging (CT/PET scans, MRIs) | \$25/visit at independent lab or office, deductible does not apply; \$200 / visit at outpatient facility. | Not covered | -----none----- |
| If you need drugs to treat your illness or condition | Tier 1 - Typically Generic | Copay /prescription: \$10 (retail), \$20 (mail order) | Reimbursed at contracted rate after specific deductible is met and \$10 copay is paid (retail) | Covers up to 31-day supply (retail); 31-90-day supply (mail order) |
| | Tier 2 - Typically Preferred / Brand | Copay /prescription: \$30 (retail), \$75 (mail order) | Reimbursed at contracted rate after specific deductible is met and \$30 copay is paid (retail) | |

* 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 | 50% coinsurance with minimum & maximum/prescription: \$50 minimum & 150 maximum (retail), \$125 minimum & \$375 maximum (mail order) | Reimbursed at contracted rate after specific deductible is met and 50% coinsurance (\$50 min/\$150 max) is paid (retail) | |
| | Tier 4 - Typically Specialty (brand and generic) | Copay /prescription: \$20 for generic; 25% coinsurance with \$50 minimum & \$150 maximum/prescription (preferred). 50% coinsurance with \$100 minimum & \$250 maximum/prescription (non-preferred) | Not covered | Covers up to 31-day supply |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$200/visit | Not covered | -----none----- |
| | Physician/surgeon fees | Deductible Only | Not covered | -----none----- |
| If you need immediate medical attention | Emergency room care | \$200/visit | Covered as In-Network | Non-emergencies are not covered. |
| | Emergency medical transportation | \$150/visit | Covered as In-Network | Non-emergency transport: not covered, except if pre-authorized. |
| | Urgent care | \$45/visit deductible does not apply | Covered as In-Network | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$400/admission | Not covered | Prior authorization is required. |
| | Physician/surgeon fees | Deductible only | Not covered | -----none----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit \$25/visit deductible does not apply Other Outpatient \$25/visit deductible does not apply | Office Visit Not covered Other Outpatient Not covered | Office Visit -----none----- Other Outpatient -----none----- |
| | Inpatient services | \$400/admission | Not covered | Prior authorization is required. |
| If you are pregnant | Office visits | \$25/visit deductible does not apply | Not covered | Maternity care may include tests and services described elsewhere in the |

* 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) | |
| | Childbirth/delivery professional services | Deductible Only | Not covered | SBC (i.e. ultrasound). Deductible does not apply to newborn on initial stay. |
| | Childbirth/delivery facility services | \$400/admission | Not covered | |
| If you need help recovering or have other special health needs | Home health care | \$45/visit <u>deductible</u> does not apply | Not covered | 200 visits/benefit period including private duty nursing. One visit equals up to 8 hours. Prior authorization is required. |
| | Rehabilitation services | \$25/visit <u>deductible</u> does not apply | Not covered | 60 visits/calendar year for Physical & Occupational Therapy combined, 90 visits/calendar year for Speech Therapy |
| | Habilitation services | \$25/visit <u>deductible</u> does not apply | Not covered | -----none----- |
| | Skilled nursing care | \$400/admission | Not covered | 120 days limit/benefit period. Prior authorization is required. |
| | Durable medical equipment | \$25 copay <u>deductible</u> does not apply | Not covered | DME is covered based on medical necessity criteria. Excludes repairs for misuse/abuse. |
| | Hospice services | \$400/admission | Not covered | Outpatient subject to \$45 copay. Prior authorization is required. |
| If your child needs dental or eye care | Children's eye exam | \$25/visit <u>deductible</u> does not apply | Not covered | 1 routine eye exam/calendar year |
| | 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](#).)

- | | | |
|--------------------|------------------------------------|---|
| • Cosmetic surgery | • Dental care (Adult and Children) | • Routine foot care unless you have been diagnosed with diabetes. |
| • Long-term care | • Weight loss programs | |

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture
- Fertility treatment maximum per lifetime per individual of \$24,000 for medical expenses and \$7,500 for prescription drug expenses
- Routine eye exam 1 visit per year
- Chiropractic care 20 visits/benefit period.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Bariatric surgery limited to treatment received at Blue Distinction Centers
- Hearing aids one pair every 3 benefit periods for subscriber and spouse. One pair every 2 benefit periods for eligible dependents.
- Private-duty nursing is only covered in the home. 200 visits/benefit period including [home health care](#). One visit equals up to 8 hours.

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.

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

[Minimum Essential Coverage](#) generally includes [plans](#), health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

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 | \$250 |
| ■ Specialist copayment | \$45 |
| ■ Hospital (facility) copayment | \$400 |
| ■ 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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$250 |
| Copayments | \$400 |
| Coinsurance | \$1,100 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$1,820 |

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 | \$45 |
| ■ Hospital (facility) copayment | \$400 |
| ■ 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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$100 |
| Copayments | \$300 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$4,300 |
| The total Joe would pay is | \$4,700 |

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$250 |
| ■ Specialist copayment | \$45 |
| ■ Hospital (facility) copayment | \$400 |
| ■ 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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| Deductibles | \$250 |
| Copayments | \$300 |
| Coinsurance | \$400 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$10 |
| The total Mia would pay is | \$960 |

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 (855) 593-8123

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 593-8123 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 593-8123.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 593-8123:

Bassa (Bàsɔ̀ Wùdù): M̂ dyi dyi-diè-djè b̂é b̂édjé b̂á céè-djè nià ke dyí ní, ɔ̀ m̂ò ni dyí-b̂édjèin-djè b̂é m̂ ké gbo-kpá-kpá kè b̂ǎ kpǎ djé m̂ bídí-wùdùùn b̂ó pídyi. B̂é m̂ ké wuɖu-zìin-nyò d̂ò gbo wùdù ke, d̂á (855) 593-8123.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 593-8123 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 593-8123 သို့ ခေါ်ဆိုပါ။

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 (855) 593-8123。

Dinka (Dinka): Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (855) 593-8123.

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 (855) 593-8123.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 593-8123 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 (855) 593-8123.

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 (855) 593-8123.

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 (855) 593-8123.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (855) 593-8123.

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 (855) 593-8123.

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 (855) 593-8123 ।

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 (855) 593-8123.

Igbo (Igbo): O bur u na i nwere ajuju o buła gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o buła. Ka gi na okowa okwu kwuo okwu, kpoo (855) 593-8123.

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 (855) 593-8123.

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 (855) 593-8123.

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 (855) 593-8123

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、(855) 593-8123 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (855) 593-8123 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 593-8123.

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