



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 (866) 578-4439 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,500/person or \$3,000/family for In- Network Providers . \$3,000/person or \$6,000/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 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$4,925/person or \$9,850/family for In- Network Providers . \$6,000/person or \$12,000/family for Out-of- Network 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 ?	Prescription Drugs , 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, Blue Preferred. See www.anthem.com or call (866) 578-4439 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	No.	You can see the specialist you choose without a referral .

to see a [specialist](#)?



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	\$30/visit	30% coinsurance	-----none-----
	Specialist visit	\$50/visit	30% coinsurance	-----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)	10% coinsurance	30% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/ National	Tier 1 - Typically Generic	\$5/prescription (retail) and \$12.50/prescription (mail order)	\$5/prescription (retail)	*See Prescription Drug section \$1,925/person or \$3,850/family prescription Out-Of-Pocket maximum Retail: 30 day supply, Mail Order: 90 day supply
	Tier 2 - Typically Preferred / Brand	\$25/prescription (retail) and \$62.50/prescription (mail order)	\$25/prescription (retail)	
	Tier 3 - Typically Non- Preferred / Specialty Drugs	\$50/prescription (retail) and \$125/prescription (mail order)	\$50/prescription (retail)	
	Tier 4 - Typically Specialty (brand and generic)	\$50/prescription (retail) and \$125/prescription (mail order)	\$50/prescription (retail)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	-----none-----
	Physician/surgeon fees	10% coinsurance	30% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	\$100/visit then 10% coinsurance	Covered as In- Network	If admitted inpatient, ER copay is waived.
	Emergency medical transportation	10% coinsurance	Covered as In- Network	-----none-----
	Urgent care	\$30/visit	30% coinsurance	-----none-----
If you have a	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	-----none-----

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdbs/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)	
hospital stay	Physician/surgeon fees	10% coinsurance	30% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$30/visit Other Outpatient 10% coinsurance	Office Visit 30% coinsurance Other Outpatient 30% coinsurance	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	10% coinsurance	30% coinsurance	-----none-----
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	100 visits/individual/benefit period.
	Rehabilitation services	10% coinsurance	30% coinsurance	*See Therapy Services section
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	10% coinsurance	30% coinsurance	90 days limit/confinement.
	Durable medical equipment	10% coinsurance	30% coinsurance	*See Durable Medical Equipment Section
	Hospice services	10% coinsurance	30% coinsurance	-----none-----
If your child needs dental or eye care	Children's eye exam	10% coinsurance (Diagnostic) \$50 copayment (Comprehensive Preventative)	30% coinsurance (Diagnostic) Not covered (Comprehensive Preventative)	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

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

- | | | |
|--|---|---|
| <ul style="list-style-type: none">• Acupuncture• Dental care(adult)• Habilitation services• Long- term care | <ul style="list-style-type: none">• Bariatric Surgery• Dental Check-up• Hearing aids• Routine foot care unless you have been diagnosed with diabetes | <ul style="list-style-type: none">• Cosmetic Surgery• Glasses for a child• Infertility treatment• Weight loss programs |
|--|---|---|

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

- | | | |
|--|--|--|
| <ul style="list-style-type: none">• Chiropractic care• Routine eye care (adult) | <ul style="list-style-type: none">• Most coverage provided outside the United States. See www.bcbsglobalcore.com | <ul style="list-style-type: none">• Private-duty nursing |
|--|--|--|

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](#), PO Box 54159, Los Angeles, CA 90054-0159.

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

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/eocdbs/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)

n The plan's overall deductible	\$1,500
n Specialist copayment	\$50
n Hospital (facility) coinsurance	10%
n 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$50
Coinsurance	\$1,130
What isn't covered	
Limits or exclusions	\$100
The total Peg would pay is	\$2,780

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

n The plan's overall deductible	\$1,500
n Specialist copayment	\$50
n Hospital (facility) coinsurance	10%
n 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$200
Coinsurance	\$590
What isn't covered	
Limits or exclusions	\$50
The total Joe would pay is	\$2,340

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

n The plan's overall deductible	\$1,500
n Specialist copayment	\$50
n Hospital (facility) coinsurance	10%
n 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$150
Coinsurance	\$40
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,690

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 (866) 578-4439 .

-4439 .

Gujarati (ગુજરાતી): , (866) 578-4439 .

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 (866) 578-4439 .

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 (866) 578-4439 ।

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 (866) 578-4439 .

Igbo (Igbo): • b•r• na •nwere aj•j• • b•la gbasara akw•kw• a, •nwere ikike •nweta enyemaka na ozi n'as•s• g•na akw•gh••gw• • b•la. Ka g•na •k•wa okwu kwuo okwu, kp•• (866) 578-4439 .

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 (866) 578-4439 .

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 (866) 578-4439 .

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 (866) 578-4439

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、(866) 578-4439 にお電話ください。

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 (866) 578-4439 .

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. (866) 578-4439 .

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 (866) 578-4439 .

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 (866) 578-4439 .

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 (866) 578-4439 .

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 (866) 578-4439 .

Thai (•••):

(866) 578-4439

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (866) 578-4439 .

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، (866) 578-4439 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý v• có b•t k• th•c m•c nào v• tài li•u này, quý v• có quy•n nh•n s• tr• giúp và thông tin b•ng ngôn ng• c•a quý v• hoàn toàn mi•n phí. •• trao ••i v•i m•t thông d•ch viên, hãy g•i (866) 578-4439 .

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (866) 578-4439.

Yoruba (Yorùbá): Tí o bá ní èyíkéyí ibèrè nípa àkọsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ̀ lọ́fẹ́fẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (866) 578-4439 .

Language Access Services:

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.