



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/>. 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) 811-3106 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$3,000/member or \$9,000/family for In- <a href="#">Network Providers</a> . \$9,000/member or \$27,000/family for Non- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Primary Care. <a href="#">Specialist</a> Visit. <a href="#">Preventive Care</a> . Certain <a href="#">Prescription Drugs</a> . For more information see below.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$6,500/member or \$13,000/family for In- <a href="#">Network Providers</a> . \$19,500/member or \$39,000/family for Non- <a href="#">Network Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Pre-Authorization</a> Penalties, <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes, PPO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (877) 811-3106 for a list of <a href="#">network providers</a> . Costs may vary by site of service and how the provider bills.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> .

		for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-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	Same as In- <a href="#">Network</a>	\$30/visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	Other cost shares may apply depending on services provided. Virtual visits (Telehealth) benefits available.
	<a href="#">Specialist</a> visit	Same as In- <a href="#">Network</a>	\$60/visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	Other cost shares may apply depending on services provided. Virtual visits (Telehealth) benefits available.
	<a href="#">Preventive care</a> / <a href="#">screening</a> /immunization	Same as In- <a href="#">Network</a>	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you need drugs to treat your illness or condition  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>	Tier 1 - Typically Generic	\$15/prescription, <a href="#">deductible</a> does not apply (retail) and \$30.00/prescription, <a href="#">deductible</a> does not apply (home delivery)	\$25/prescription, <a href="#">deductible</a> does not apply (retail only)	Not covered (retail and home delivery)	Precertification may be required for certain <a href="#">Prescription Drugs</a> . Please note that certain <a href="#">Specialty</a> Drugs are only available from the <a href="#">Specialty</a> Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. For more information, refer to "Essential Drug List" at
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	\$50/prescription, <a href="#">deductible</a> does not apply (retail) and \$125/prescription,	\$60/prescription, <a href="#">deductible</a> does not apply (retail only)	Not covered (retail and home delivery)	

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
Common Medical Event		<u>deductible</u> does not apply (home delivery)			<a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a> *See Prescription Drug Section of your evidence of coverage, available in the footnote below.
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	\$75/prescription, <u>deductible</u> does not apply (retail) and \$187.50/prescription, <u>deductible</u> does not apply (home delivery)	\$85/prescription, <u>deductible</u> does not apply (retail only)	Not covered (retail and home delivery)	
	Tier 4 - Typically Preferred Specialty (brand and generic)	30% <u>coinsurance</u> up to \$350/prescription, <u>deductible</u> does not apply (retail and home delivery)	30% <u>coinsurance</u> up to \$500/prescription, <u>deductible</u> does not apply (retail only)	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Same as In- <u>Network</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	Same as In- <u>Network</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	Same as In- <u>Network</u>	30% <u>coinsurance</u>	Covered as In- <u>Network</u>	-----none-----
	<u>Emergency medical transportation</u>	Same as In- <u>Network</u>	30% <u>coinsurance</u>	Covered as In- <u>Network</u>	-----none-----
	<u>Urgent care</u>	Same as In- <u>Network</u>	\$60/visit <u>deductible</u> does not apply	50% <u>coinsurance</u>	Other cost shares may apply depending on services provided.
If you have a hospital stay	Facility fee (e.g., hospital room)	Same as In- <u>Network</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	150 days/benefit period for Inpatient rehabilitation and skilled nursing services combined for In- <u>Network</u> and Non- <u>Network Providers</u> combined.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Same as In- <a href="#">Network</a>	Office Visit \$30/visit <a href="#">deductible</a> does not apply Other Outpatient 30% <a href="#">coinsurance</a>	Office Visit 50% <a href="#">coinsurance</a> Other Outpatient 50% <a href="#">coinsurance</a>	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you are pregnant	Office visits	Same as In- <a href="#">Network</a>	\$250/pregnancy <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	One <a href="#">copayment</a> per pregnancy for both office visits and childbirth/delivery professional services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Same as In- <a href="#">Network</a>	\$250/pregnancy <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Not covered	100 visits/benefit period for Home Health and Private Duty Nursing combined for In- <a href="#">Network</a> and Non- <a href="#">Network Providers</a> combined.
	<a href="#">Rehabilitation services</a>	Same as In- <a href="#">Network</a>	\$30/visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	20 visits each for Physical, Speech and Occupational therapy/benefit period.
	<a href="#">Habilitation services</a>	Same as In- <a href="#">Network</a>	\$30/visit <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a>	Habilitation visits count towards your rehabilitation limit.
	<a href="#">Skilled nursing care</a>	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	150 days/benefit period for Inpatient rehabilitation and skilled nursing services combined for In- <a href="#">Network</a> and

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
					Non- <u>Network Providers</u> combined.
	<u>Durable medical equipment</u>	Same as In- <u>Network</u>	30% <u>coinsurance</u>	Not covered	*See <u>Durable Medical Equipment</u> Section
	<u>Hospice services</u>	Same as In- <u>Network</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If your child needs dental or eye care	Children's eye exam	Not Applicable	No charge	\$0 <u>copayment</u> up to <u>plan's Maximum Allowed Amount</u>	*See Vision Services Section of your evidence of coverage, available in the footnote below.
	Children's glasses	Not covered	Not covered	Not covered	*See Vision Services Section of your evidence of coverage, available in the footnote below.
	Children's dental check-up	Not covered	Not covered	Not covered	-----none-----

#### 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.)

- Bariatric surgery
- Dental care (Pediatric)
- Hearing aids (18+)
- Routine foot care unless you have been diagnosed with diabetes
- Cosmetic surgery
- Dental Check-up
- Long-term care
- Weight loss programs
- Dental care (Adult)
- Glasses for a child
- Preadmission - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. Contact us to find out what must be preauthorized and whether preauthorization has been given.

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

- Acupuncture 20 visits/benefit period combined with Massage Therapy
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Chiropractic care 20 visits/benefit period
- Private-duty nursing 100 visits/benefit period combined with Home Health
- Infertility treatment
- Routine eye care (Adult) 1 exam/benefit period

\* For more information about limitations and exceptions, see plan or policy document at <https://eoc.anthem.com/eocdps/>.

**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: Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or contact Anthem at the number on the back of your ID card. 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 on how 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, 700 Broadway, Mail Stop CO0104-0430, Denver, CO 80273

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490

**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/>.

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$2,100

#### *What isn't covered*

Limits or exclusions      \$60  
The total Peg would pay is      \$5,460

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$1,700
<a href="#">Coinsurance</a>	\$0

#### *What isn't covered*

Limits or exclusions      \$20  
The total Joe would pay is      \$1,820

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,100
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0

#### *What isn't covered*

Limits or exclusions      \$0  
The total Mia would pay is      \$2,400

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 (877) 811-3106

**Amharic (አማርኛ):** አለሁ ሰነድ ማንኛውም ብቻ ከለዋቸው በፈለጊ ቅጽ እና ይህን መረጃ በለን የሚገኘት መብት አለዋቸው:: አስተርጓሚ ለማናገር (877) 811-3106 የደጋጋሚ::

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 811-3106 . (877)

**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՝ (877) 811-3106:

**Bassa (Basa Wùqdù):** M dyi dyi-diè-dè bë bëdë bá céè-dè nià ke dyi ní, o mò nì dyi-bëdëin-dè bë bë mì kë gbo-kpá-kpá kë bë kpë qé mì bídí-wùqdùún bò pídyi. Bé mì kë wuqu-zìin-nyò dò gbo wùqdù ke, qá (877) 811-3106.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাসীর সাথে কথা খান জন্য (877) 811-3106 -তে কল করুন।

**Burmese (မြန်မာ):** ဤတရုပ်တတ်နှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကုအညီကို အကြောင်းငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားမြန် တစ်ဦးနှင့် စကားမြောနိုင်ရန် ဖု (877) 811-3106 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(877) 811-3106。

**Dinka (Dinka):** Na nɔj thiēc nē ke de yā thorē, ke yin nɔj loj bë yi kuony ku wər alēu bë gəer yic yin ne thɔj du ke cin wēu tāāuē ke piny. Te kɔr yin ba jam wēnē ran ye thok geryic, ke yin col (877) 811-3106.

**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 (877) 811-3106.

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