



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:
What is the overall <a href="#">deductible</a> ?	\$2,000/member or \$6,000/family for In- <a href="#">Network Providers</a> . \$6,000/member or \$18,000/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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Primary Care. <a href="#">Specialist Visit</a> . <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> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$5,000/member or \$10,000/family for In- <a href="#">Network Providers</a> . \$15,000/member or \$30,000/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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Pre-Authorization Penalties</a> , <a href="#">Premiums</a> , <a href="#">balance-billing charges</a> , 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> .
Will you pay less if you use a <a href="#">network provider</a> ?	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 <a href="#">provider's</a> 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>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	Same as In- <a href="#">Network</a>	20% <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 \$37.50/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 Drugs</a> are only available from the <a href="#">Specialty Pharmacy</a> 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 \$150/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)	
		<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 \$225/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>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	Same as In- <u>Network</u>	20% <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>	20% <u>coinsurance</u>	Covered as In- <u>Network</u>	-----none-----
	<u>Emergency medical transportation</u>	Same as In- <u>Network</u>	20% <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>	20% <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>	20% <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 20% <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>	20% <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>	20% <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>	20% <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>	20% <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- <a href="#">Network Providers</a> combined.
	<a href="#">Durable medical equipment</a>	Same as In- <a href="#">Network</a>	20% <a href="#">coinsurance</a>	Not covered	*See <a href="#">Durable Medical Equipment</a> Section
	<a href="#">Hospice services</a>	Same as In- <a href="#">Network</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
<b>If your child needs dental or eye care</b>	Children’s eye exam	Not Applicable	No charge	\$0 <a href="#">copayment</a> up to <a href="#">plan's</a> Maximum <a href="#">Allowed Amount</a>	*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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Dental care (Pediatric)</li> <li>Hearing aids (18+)</li> <li>Routine foot care unless you have been diagnosed with diabetes</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic surgery</li> <li>Dental Check-up</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (Adult)</li> <li>Glasses for a child</li> <li><a href="#">Preauthorization</a> - 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 <a href="#">preauthorization</a> has been given.</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Acupuncture 20 visits/benefit period combined with Massage Therapy</li> <li>Most coverage provided outside the United States. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a></li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care 20 visits/benefit period</li> <li>Private-duty nursing 100 visits/benefit period combined with Home Health</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Routine eye care (Adult) 1 exam/benefit period</li> </ul>

\* 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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$60	■ <a href="#">Specialist copayment</a>	\$60	■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%
<p>This EXAMPLE event includes services like:</p> <p><a href="#">Specialist</a> office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)  <a href="#">Specialist</a> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Primary care physician</a> office visits (<i>including disease education</i>)  <a href="#">Diagnostic tests</a> (<i>blood work</i>)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Emergency room care</a> (<i>including medical supplies</i>)  <a href="#">Diagnostic test</a> (<i>x-ray</i>)  <a href="#">Durable medical equipment</a> (<i>crutches</i>)  <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,000	<a href="#">Deductibles</a>	\$100	<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$300	<a href="#">Copayments</a>	\$1,700	<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$1,600	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$20
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,960</b>	<b>The total Joe would pay is</b>	<b>\$1,820</b>	<b>The total Mia would pay is</b>	<b>\$2,320</b>

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):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በገና የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (877) 811-3106 ይደውሉ።

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

**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 (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄èdjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̀ b̄ídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̀á (877) 811-3106.

**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 (877) 811-3106 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် 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。

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