



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 (800) 922-6621 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0/individual or \$0/2-person or \$0/family for In- Network Providers . \$1,500/single or \$3,000/2-person or \$4,500/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 ?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Yes. \$50 for Out-of- Network Providers for Home Health Care . 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 ?	\$6,600/individual or \$13,200/2-person or \$13,200/family for In- Network Providers . \$6,000/individual or \$12,000/2-person or \$18,000/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 ?	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, PPO. See www.anthem.com or call (800) 922-6621 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	\$30/visit	20% coinsurance	-----none-----
	Specialist visit	\$40/visit	20% coinsurance	-----none-----
	Preventive care/screening/immunization	No charge	20% 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)	No charge	20% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	\$100	20% 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	\$10/prescription (retail) and \$20/prescription (home delivery)	20% coinsurance of the In- Network allowance plus the difference between Anthem Blue Cross and Blue Shield's payment and the pharmacist's actual charge.	*Unlimited Drug Maximum See Prescription Drug section
	Tier 2 - Typically Preferred / Brand	\$25/prescription (retail) and \$50/prescription (home delivery)	20% coinsurance of the In- Network allowance plus the difference between Anthem Blue Cross and Blue Shield's payment and the pharmacist's actual charge.	
	Tier 3 - Typically Non-Preferred / Specialty Drugs	\$40/prescription (retail) and \$80/prescription (home delivery)	20% coinsurance of the In- Network allowance plus the difference between Anthem Blue Cross and Blue Shield's payment and the pharmacist's actual charge.	
	Tier 4 - Typically Specialty Drugs	Not Applicable	Not Applicable	

* 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100/visit	20% coinsurance	Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fees	No charge	20% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	\$175/visit	Covered as In- Network	Copay waived if admitted.
	Emergency medical transportation	No charge	Covered as In- Network	-----none-----
	Urgent care	\$30/visit	Not covered	Walk-in-centers: \$40/visit for In- Network Providers and 20% coinsurance for Non- Network Providers .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300/admission	20% coinsurance	Copay is waived if readmitted within 30 days for same diagnosis. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
	Physician/surgeon fees	No charge	20% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$30/visit Other Outpatient 30/visit	Office Visit 20% coinsurance Other Outpatient 20% coinsurance	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	\$300/admission	20% coinsurance	Copay is waived if readmitted within 30 days for same diagnosis. Failure to obtain preauthorization may result in non-coverage or reduced coverage.
If you are pregnant	Office visits	\$40/visit	20% coinsurance	Copay applies to initial visit. There may be other levels of cost share that are contingent on how services are provided. Copay is waived if readmitted within 30 days for same diagnosis. Failure to obtain preauthorization may result in non-coverage or reduced coverage. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	\$300/admission	20% coinsurance	
	Home health care	No charge	20% coinsurance	200 visits/ benefit period.

* 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	No charge	20% coinsurance	*See Therapy Services section
	Habilitation services	No charge	20% coinsurance	
	Skilled nursing care	\$300/admission	20% coinsurance	120 day limit/benefit period. Copay is waived if readmitted within 30 days for same diagnosis. Failure to obtain preauthorization may result in non-coverage or reduced coverage. Copay is waived if admitted within 3 days of hospital discharge.
	Durable medical equipment	No charge	20% coinsurance	-----none-----
	Hospice services	No charge	20% coinsurance	-----none-----
If your child needs dental or eye care	Children's eye exam	No charge	20% 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](#).)

- Cosmetic surgery
- Routine foot care unless you have been diagnosed with diabetes.
- Dental care (adult)
- Weight loss programs
- Long- term care

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

- Acupuncture
- Hearing aids
- Private-duty nursing
- Bariatric surgery
- Infertility treatment
- Routine eye care (adult)
- Chiropractic care 50 visits/benefit period.
- Most coverage provided outside the United States www.bcbs.com/bluecardworldwide

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

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, at 1-877-267-2323 x61565 or 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, P.O. Box 1038, North Haven, CT 06473-4201

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.

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	\$0
■ Specialist copayment	\$20
■ Hospital (facility) copayment	\$250
■ 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	\$0
Copayments	\$560
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$620

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$20
■ Hospital (facility) copayment	\$250
■ 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	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$21
The total Joe would pay is	\$221

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$20
■ Hospital (facility) copayment	\$250
■ 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	\$0
Copayments	\$285
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$285

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 (800) 922-6621

[illegible]

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 922-6621 (800).

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՝ (800) 922-6621:

Bassa (Bàsɔ̀ Wùdù): M̃ dyi dyi-diè-dɛ bɛ́ bédé bá cée-dɛ nìà kɛ dyí ní, ɔ̀ mò nì dyí-bèdɛ̀n-dɛ bɛ́ m̃ kɛ gbo-kpá-kpá kè b̃́ kp̃́ dɛ m̃ bídí-wùdù̀n b́́ pídyi. Bɛ́ m̃ kɛ wudu-zìin-nyò d̀ò gbo wùdù kɛ, d́́ (800) 922-6621.

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 (৪০০) ৯২২-৬৬২১ -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (800) 922-6621 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 (800) 922-6621。

Dinka (Dinka): Na nŋ thiēc nē ke de yā thorē, ke yin nŋ loŋ bē yi kuony ku wēr alēu bē gēer yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te kōr yin ba jam wēnē ran ye thok geryic, ke yin cōl (800) 922-6621.

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 (800) 922-6621.

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 922-6621 (800) 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 (800) 922-6621.

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 (800) 922-6621.

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 (800) 922-6621.

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 (800) 922-6621.

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 entèprete, rele (800) 922-6621.

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 (800) 922-6621 ।

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 (800) 922-6621.

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 (800) 922-6621.

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 (800) 922-6621.

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 (800) 922-6621.

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 (800) 922-6621

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、(800) 922-6621 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (800) 922-6621 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (800) 922-6621.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (800) 922-6621 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັກກັບລ່າມເປພາສາ, ໃຫ້ໂທຫາ (800) 922-6621.

Navajo (Diné): Díí naaltsoos biká'ígíí lahgo bina'idíílkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjį bee níl hodoonih t'áadoo báąh ilinígóó. Ata' halne'ígíí lá' bich'i' hadeesdzih nínízingo kojį' hodiílnih (800) 922-6621.

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 (800) 922-6621

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (800) 922-6621 bilbilla.

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