




The Summary of Benefits and Coverage (SBC) document will help you choose a [healthplan](#). 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/fi>. 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) 542-9402 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,000 /single or \$6,000 /family for In- Network Providers . \$4,000 /single or \$12,000 /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?	\$6,000 /single or \$12,700 /family for In- Network Providers . \$13,000 /single or \$30,000 /family for Out-of- Network Providers .	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Pre-Authorization Penalties, 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) 542-9402 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 .
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 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)	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	\$40/visit plus 25% coinsurance for all other services	50% coinsurance	In-network: coinsurance charged for any services not billed as an office visit.
	Specialist visit	\$70/visit plus 25% coinsurance for all other services	50% coinsurance	In-network: coinsurance charged for any services not billed as an office visit.
	Preventive care / screening /immunization	No charge	\$70/PCP visit or \$100/Specialist visit; \$500 copayment for covered colonoscopy facility services	There may be other levels of cost share that are contingent on how services are provided. 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% coinsurance at a hospital-based facility, or 100% covered at a free-standing or non-hospital-based facility	50% coinsurance	-----none-----
	Imaging (CT/PET scans, MRIs)	25% coinsurance at a hospital-based facility, or \$150 copayment at a free-standing or non-hospital-based facility	50% coinsurance	Failure to obtain pre-authorization may result in reduced or no coverage.
If you need drugs to treat your illness or condition	Tier1 - Typically Generic	\$15/prescription (Retail/Mail order)	Not covered	Retail includes a 30-day supply; Mail order includes a 90-day supply.
	Tier2 - Typically Preferred / Brand	\$50/prescription (Retail) \$100/prescription (Mail order)	Not covered	Certain specialty drugs must be ordered through a specialty pharmacy; see the contract plan for details.
	Tier3 - Typically Non-Preferred / Specialty Drugs	\$80/prescription (Retail) \$160/prescription (Mail order)	Not covered	Diabetic medication and supplies are covered under the tier 1 \$15 copayment.
	Tier4 - Typically Specialty Drugs	30% copayment with maximum payment of	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/		\$350/prescription (Retail) \$350/prescription (Mail order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance at a hospital-based facility; or \$250/surgery at a free-standing non-hospital-based facility, not subject to deductible	50% coinsurance	-----none-----
	Physician/surgeon fees	25% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	25% coinsurance	Covered as In- Network	-----none-----
	Emergency medical transportation	25% coinsurance	Covered as In- Network	-----none-----
	Urgent care	\$70/visit plus 25% coinsurance for all other services	50% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 150 days combined per benefit period.
	Physician/surgeon fees	25% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40/office visit, or 25% coinsurance for outpatient facility	50% coinsurance	-----none-----
	Inpatient services	25% coinsurance	50% coinsurance	-----none-----
If you are pregnant	Office visits	PCP: \$40/pregnancy Specialist: \$70/ pregnancy plus 25% coinsurance for all other services	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	Not covered	60 visits/year for In- Network Providers .
	Rehabilitation services	25% coinsurance	50% coinsurance	*See Therapy Services section
	Habilitation services	25% coinsurance	50% coinsurance	
	Skilled nursing care	25% coinsurance	50% coinsurance	Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 150 days combined per benefit period.
	Durable medical equipment	25% coinsurance	Not covered	-----none-----
	Hospice services	25% coinsurance	50% coinsurance	-----none-----
If you need dental or eye care	Eye exam	\$40/visit	Maximum \$35 reimbursement	Covers 1 routine refraction exam every 12 months.
	Glasses	Not covered	Not covered	
	Dental check-up	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](#).)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Glasses for a child
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes.
- Cosmetic surgery
- Hearing aids
- [Preauthorization](#) - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. To find out which services require Preauthorization and to be sure that Preauthorization has been given, you may contact us.
- Weight loss programs
- Dental care (adult)
- Infertility treatment
- Private-duty nursing

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

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

- Acupuncture (limits apply)
- Bariatric surgery (limits apply)
- Most coverage provided outside the United States www.bcbsglobalcore.com
- Chiropractic Care (limits apply)

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's Employee Benefits Security Administration at (866) 444-EBSA (3272) or 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, 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

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

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/eocdps/fi>.

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	\$2,000
■ Specialist copayments	\$70
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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	\$2,000
Copayments	\$100
Coinsurance	\$2,685
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$4,785

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

■ The plan's overall deductible	\$2,000
■ Specialist copayments	\$70
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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	\$2,000
Copayments	\$125
Coinsurance	\$1,334
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$3,459

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

■ The plan's overall deductible	\$2,000
■ Specialist copayments	\$70
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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	\$2,000
Copayments	\$0
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,010

The [plan](#) would be responsible for the other costs of these EXAMPLE covered 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) 333-5735

Amharic (አማርኛ): ለትኩረት ወይም ለተጨማሪ መረጃ ይጻፉን። ለተጨማሪ መረጃ ወይም ለትኩረት ይጻፉን። (855) 333-5735 ይጻፉን።

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) 333-5735.

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) 333-5735:

Bassa (Bàsɔ̀ Wùdù): M̄ dyi dyi-diè-dɛ̀ bɛ̀ bédé bá céè-dɛ̀ nià ke dyí ní, ɔ̀ m̀ò ni dyí-bɛ̀dɛ̀in-dɛ̀ bɛ̀ m̄ ké gbo-kpá-kpá kè b̄́ kp̄́ dɛ̀ m̄ bídɛ̀-wùdù̀n̄ b́́ pídyi. Bɛ̀ m̄ ké wuɖu-zìin-nyò d̀ò gbo wùdù̀ ke, d́́ (855) 333-5735.

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) 333-5735 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 333-5735 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) 333-5735。

Dinka (Dinka): Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ loŋ bē yi kuony ku wɛr alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cəl (855) 333-5735.

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) 333-5735.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 333-5735 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) 333-5735.

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) 333-5735.

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) 333-5735.

Gujarati (ગુજરાતી): જો તમે આ દસ્તાવેજ વિશે કોઈ પ્રશ્નો ધરાવો છો, તો તમને આ માહિતી અને મદદ વિના કોઈ પણ ખર્ચ વિના મળી શકે છે. જો તમને અનુભવે છે કે તમને સહાયતાની જરૂર છે, તો કૃપા કરીને (855) 333-5735 નંબર પર કોલ કરો.

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) 333-5735.

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) 333-5735 ।

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) 333-5735.

Igbo (Igbo): O bụrụ na ị nwere ajụjụ 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 (855) 333-5735.

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) 333-5735.

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) 333-5735.

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) 333-5735

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) 333-5735 にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (855) 333-5735 ។

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) 333-5735.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 333-5735 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ນລັກກັບວ່າມແບພາສາ, ໃຫ້ໂທຫາ (855) 333-5735.

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