



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/](http://www.healthcare.gov/sbc-glossary/) or call (800) 542-9402 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>\$2,000</b> /single or <b>\$6,000</b> /family for In- <a href="#">Network Providers</a> . <b>\$4,000</b> /single or <b>\$12,000</b> /family for Out-of- <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. <a href="#">Preventive care</a> for In- <a href="#">Network Providers</a> .	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 preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services 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> ?	<b>\$6,000</b> /single or <b>\$12,700</b> /family for In- <a href="#">Network Providers</a> . <b>\$13,000</b> /single or <b>\$30,000</b> /family for Out-of- <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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Pre-Authorization 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> .
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 (800) 542-9402 for a list of <a href="#">network providers</a> .	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 out-of- <a href="#">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 out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$40/visit plus 25% coinsurance for all other services	50% <a href="#">coinsurance</a>	In-network: coinsurance charged for any services not billed as an office visit.
	<a href="#">Specialist</a> visit	\$70/visit plus 25% coinsurance for all other services	50% <a href="#">coinsurance</a>	In-network: coinsurance charged for any services not billed as an office visit.
	<a href="#">Preventive care</a> / <a href="#">screening</a> /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 <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)	25% coinsurance at a hospital-based facility, or 100% covered at a free-standing or non-hospital-based facility	50% <a href="#">coinsurance</a>	-----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% <a href="#">coinsurance</a>	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 / <a href="#">Specialty Drugs</a>	\$80/prescription (Retail) \$160/prescription (Mail order)	Not covered	Diabetic medication and supplies are covered under the tier 1 \$15 copayment.
	Tier4 - Typically <a href="#">Specialty Drugs</a>	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 <a href="http://www.anthem.com/pharmacyinformation/">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>		\$100/prescription (Retail) \$200/prescription (Mail order)		
<b>If you have outpatient surgery</b>	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% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	25% coinsurance	50% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	25% coinsurance	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Emergency medical transportation</a>	25% coinsurance	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	\$70/visit plus 25% coinsurance for all other services	50% <a href="#">coinsurance</a>	-----none-----
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	25% coinsurance	50% <a href="#">coinsurance</a>	30 day limit/benefit year for Inpatient Rehabilitation.
	Physician/surgeon fees	25% coinsurance	50% <a href="#">coinsurance</a>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$40/office visit, or 25% coinsurance for outpatient facility	50% coinsurance	-----none-----
	Inpatient services	25% coinsurance	50% coinsurance	-----none-----
<b>If you are pregnant</b>	Office visits	PCP: \$40/pregnancy Specialist: \$70/ pregnancy plus 25% coinsurance for all other services	50% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

\* 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)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	25% <a href="#">coinsurance</a>	Not covered	60 visits/year for In- <a href="#">Network Providers</a> .
	<a href="#">Rehabilitation services</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	*See Therapy Services section
	<a href="#">Habilitation services</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	100 day limit/year.
	<a href="#">Durable medical equipment</a>	25% <a href="#">coinsurance</a>	Not covered	-----none-----
	<a href="#">Hospice services</a>	25% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----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

**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](http://www.bcbsglobalcore.com)
- Chiropractic Care (limits apply)

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

**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](http://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](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 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**

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](#).

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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\* 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayments</a>	\$70
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$100
<a href="#">Coinsurance</a>	\$2,685
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,785</b>

### 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>	\$2,000
■ <a href="#">Specialist copayments</a>	\$70
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$125
<a href="#">Coinsurance</a>	\$1334
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$3,459</b>

### 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
■ <a href="#">Specialist copayments</a>	\$70
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,010</b>

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):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 333-5735 ይደውሉ።

**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 b́á céè-dɛ̀ nià ke dyí ní, ɔ̀ m̀ò nì dyí-bédɛ̀in-dɛ̀ b́é m̄ ké gbo-kpá-kpá kè b̄́ kp̄́ d́é m̄ bídí-wùdùùn b́ó pídyi. B́é m̄ ké wuɔ̀u-zìin-nyò d̀ò gbo wùdù ke, d́á (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 ဖုန် (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 thorē, ke yin nɔŋ loŋ bē yi kuony ku wēr alēu bē gɛɛr yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te kōr yin ba jam wēnē ran ye thok geryic, ke yin cōl (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 (فارسي):** 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 (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 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 (855) 333-5735.

**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):** Ọ bụr ụ na ị nwere ajuju ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gi na akwụghị ụgwọ ọ bụla. Ka gi na ọkọwa okwu kwuo okwu, kpọọ (855) 333-5735.

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