




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 (844) 390-4133 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,000/individual or \$2,000/family for In- Network Providers . \$3,000/individual or \$6,000/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 and Out-of- Network Providers . Primary Care visit, Specialist visit, and Vision exam 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 ?	\$4,000/individual or \$8,000/family for In- Network Providers . \$10,000/individual or \$20,000/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 ?	Services deemed not medically necessary by Medical Management and/or Anthem, 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, Blue Card PPO. See www.anthem.com or call (844) 390-4133 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	No charge	50% coinsurance	-----none-----
	Specialist visit	\$60/visit deductible does not apply	50% coinsurance	OB/GYN \$30 OV copay
	Preventive care/screening/immunization	No charge	No charge	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)	Lab – Office No charge X-Ray – Office No charge	Lab – Office No charge X-Ray – Office 50% coinsurance	Lab – Office -----none----- X-Ray – Office -----none-----
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Tier 1 - Typically Generic	\$10 copay/retail \$20 copay mail order	Not covered	Maintenance medications must be filled as a 90 day supply via either mail order or CVS store locations
	Tier 2 - Typically Preferred / Brand	\$50 copay/retail \$100 copay mail order	Not covered	
	Tier 3 - Typically Non- Preferred	\$100 copay/retail \$200 copay mail order	Not covered	
	Tier 4 - Typically Specialty (brand and generic)	\$40 copay/generic 30 day supply; \$100 copay/preferred 30 day supply \$200 copay/NP 30 day supply	Not covered	Specialty drugs available in 30 day supply through CVS Specialty Pharmacy only
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	-----none-----
	Physician/surgeon fees	30% coinsurance	50% coinsurance	-----none-----

* 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 immediate medical attention	Emergency room care	30% coinsurance	Covered as In- Network	-----none-----
	Emergency medical transportation	30% coinsurance	Covered as In- Network	-----none-----
	Urgent care	\$60/visit; deductible does not apply	50% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	-----none-----
	Physician/surgeon fees	30% coinsurance	50% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$30/visit deductible does not apply Other Outpatient No charge	Office Visit 50% coinsurance Other Outpatient 50% coinsurance	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	30% coinsurance	50% coinsurance	-----none-----
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	120 visits/benefit period.
	Rehabilitation services	\$60/visit; deductible does not apply	50% coinsurance deductible does not apply	*See Therapy Services section
	Habilitation services	\$60/visit; deductible does not apply	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	90 days limit/benefit period.
	Durable medical equipment	30% coinsurance	50% coinsurance	-----none-----
	Hospice services	30% coinsurance	50% coinsurance	-----none-----
If your child needs dental or eye care	Children's eye exam	No charge	No charge	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

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

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

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

- Abortion
- Hearing aids \$2,000 maximum/ear every 24 months.
- Private-duty nursing 70, 8-hour shifts/benefit period/member.
- Bariatric surgery
- Infertility treatment
- Routine eye care (adult)
- Chiropractic care
- Most coverage provided outside the United States. See www.bcbsglovalcore.com

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, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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 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](#), PO Box 54159, Los Angeles, CA 90054-0159

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

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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (844) 390-4133.

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

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (844) 390-4133.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码(844) 390-4133.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' (844) 390-4133.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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	\$1,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	30%
■ 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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$100
The total Peg would pay is	\$3,400

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	30%
■ 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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$6,000
The total Joe would pay is	\$6,100

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$60
■ Hospital (facility) coinsurance	30%
■ 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	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$400
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.