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](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/](http://www.healthcare.gov/sbc-glossary/) or call (855) 502-6365 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$250/individual or $750/family for Health Sync Providers. $500/individual or $1,000/family for In-Network Providers. $1,000/individual or $2,000/family for Out-of-Network Providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care, Prescription Drugs and Primary Care office visits for Health Sync and In-Network Providers.</td>
<td>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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$5,350/individual or $10,700/family for Health Sync Providers. $6,350/individual or $12,700/family for In-Network Providers. $12,700/individual or $25,400/family for Out-of-Network Providers.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Services deemed not medically necessary by Medical Management and/or Anthem, Premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if</td>
<td>Yes, Blue Card PPO. See</td>
<td>You pay the least if you use a provider in HealthSync. You pay more if you use a provider in...</td>
</tr>
</tbody>
</table>
### If you visit a health care provider's office or clinic

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Health Sync Provider (You will pay the least)</th>
<th>In-Network Provider (You will pay more)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>10% coinsurance, deductible does not apply</td>
<td>25% coinsurance, deductible does not apply</td>
<td>50% coinsurance</td>
<td>-------none-------</td>
<td></td>
</tr>
<tr>
<td>Specialist visit</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>-------none-------</td>
<td></td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

### If you have a test

<table>
<thead>
<tr>
<th>If you have a test</th>
<th>Services You May Need</th>
<th>Health Sync Provider (You will pay the least)</th>
<th>In-Network Provider (You will pay more)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>-------none-------</td>
<td></td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>-------none-------</td>
<td></td>
</tr>
</tbody>
</table>

### If you need drugs to treat your illness or condition

More information about prescription drug coverage is available at [http://www.cvs/caremark.com](http://www.cvs/caremark.com)

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Health Sync Provider (You will pay the least)</th>
<th>In-Network Provider (You will pay more)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 - Typically Generic</td>
<td>$10 maximum/prescription (retail) and $25 maximum/prescription (home delivery)</td>
<td>$10 maximum/prescription (retail) and $25 maximum/prescription (home delivery)</td>
<td>Not covered</td>
<td>*See Prescription Drug section</td>
</tr>
</tbody>
</table>

---

* For more information about limitations and exceptions, see [plan](https://eoc.anthem.com/eocdps/aso) or policy document at [https://eoc.anthem.com/eocdps/aso](https://eoc.anthem.com/eocdps/aso).
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Health Sync Provider (You will pay the least)</th>
<th>In-Network Provider (You will pay more)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 2 - Typically Preferred / Brand</td>
<td>30% coinsurance up to $100 maximum /prescription deductible does not apply (retail) and 30% coinsurance up to $250 maximum /prescription deductible does not apply (home delivery)</td>
<td>30% coinsurance up to $100 maximum /prescription deductible does not apply (retail) and 30% coinsurance up to $250 maximum /prescription deductible does not apply (home delivery)</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3 - Typically Non-Preferred</td>
<td>40% coinsurance up to $150 maximum /prescription deductible does not apply (retail) and 40% coinsurance up to $350 maximum /prescription deductible does not apply (home delivery)</td>
<td>40% coinsurance up to $150 maximum /prescription deductible does not apply (retail) and 40% coinsurance up to $350 maximum /prescription deductible does not apply (home delivery)</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 4 - Typically Specialty (brand and generic)</td>
<td>50% coinsurance up to $250 maximum /prescription deductible does not apply (retail) and 50% coinsurance up to $250 maximum /prescription deductible does not apply (retail) and</td>
<td>50% coinsurance up to $250 maximum /prescription deductible does not apply (retail) and</td>
<td>Not covered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Health Sync Provider (You will pay the least)</td>
<td>In-Network Provider (You will pay more)</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>50% coinsurance up to $250 maximum /prescription deductible does not apply (home delivery)</td>
<td>50% coinsurance up to $250 maximum /prescription deductible does not apply (home delivery)</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>50% coinsurance up to $250 maximum /prescription deductible does not apply (home delivery)</td>
<td>50% coinsurance up to $250 maximum /prescription deductible does not apply (home delivery)</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
</tr>
</tbody>
</table>

*See Therapy Services section

*For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/aso.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Health Sync Provider (You will pay the least)</th>
<th>In-Network Provider (You will pay more)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>120 days limit/benefit period for In-Network Providers and Out-of-Network Providers combined.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>*See Durable Medical Equipment Section</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>*See Vision Services section</td>
<td></td>
</tr>
</tbody>
</table>

If your child needs dental or eye care

<table>
<thead>
<tr>
<th></th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s eye exam</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>10% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

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
- Dental care (adult)
- Infertility treatment
- Routine foot care unless you have been diagnosed with diabetes.
- Acupuncture
- Dental Check-up
- Long-term care
- Weight loss programs
- Cosmetic surgery
- Hearing aids
- Routine eye care (adult)

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.):

- Bariatric surgery
- Private-duty nursing only covered in home. 120 visits/benefit period including Home Health Care.
- Chiropractic care 26 visits/benefit period.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com

* 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, 1-877-267-2323 x61565, 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 105568, Atlanta GA 30348-5568

Does this plan provide Minimum Essential Coverage? Yes/No
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/No
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/aso.
**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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

- **The plan’s overall deductible** $250
- **Specialist coinsurance** 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$40</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,260</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $60
- **The total Peg would pay is** $1,610

- **The plan’s overall deductible** $250
- **Specialist coinsurance** 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$310</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,370</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $55
- **The total Joe would pay is** $1,990

- **The plan’s overall deductible** $250
- **Specialist coinsurance** 10%
- **Hospital (facility) coinsurance** 10%
- **Other coinsurance** 10%

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

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$190</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions $0
- **The total Mia would pay is** $440

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 përkkthyes, telefononi (855) 502-6365

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Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն վերաբերյալ այս փաստաթղթի հետ մշակված փաստաթղթի հետ կապված հարցերի համար (855) 502-6365:

Bengali (বাংলা): যদি এই প্রতিক্ষীণের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষার বিষয়ক সাহায্য পাওয়ার ও ভূষণ পাওয়ার অধিকার আপনার আছে। একজন দীর্ঘকালীন সাহায্যের জন্য কথা বলার জন্য (855) 502-6365 -তে কল করুন।

Burmese (အများကြီး) ဖွင့်ဝင်မည့်အချက်များအား လိုအပ်သောအချက်များအားလုံး အနီစားပါ။ (855) 502-6365

Chinese (中文): 如果您对本文件有任何疑问，您有权限使用您的语言免费获得协助和资讯，如需与译员通话，请致电 (855) 502-6365。

Dinka (Dinka): Na nong theëëc nè ke de yá thòrrë, ke yin noq loò bè yi kuony ku wer akë bë geër yic yin ne thönd du ke cin wënu táştë ke piny. Te kök yin ba jìm wënë ran ye thök gëryëc, ke yin col (855) 502-6365.

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) 502-6365.

Farsi (فارسی): در صورتی که سوالی 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 متراژ محلی، با شماره 6365-502-6365 تماس بگیرید.

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**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn ed ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprè, rele (855) 502-6365.

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