




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/>. 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 (877) 811-3106 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$2,000/member or \$6,000/family for In- <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. Primary Care. <a href="#">Specialist Visit</a> . <a href="#">Preventive Care</a> . For more information see below.	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 <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> 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?	Yes. \$200/member or \$400/family for <a href="#">Prescription Drugs</a> for Level 1 Pharmacy-RX Only and In- <a href="#">Network Providers</a> combined. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$6,350/member or \$12,700/family for In- <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. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<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, HMO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (877) 811-3106 for a list of <a href="#">network providers</a> . Costs may vary by site of service and how the	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 <a href="#">out-of-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 <a href="#">out-of-network provider</a>

	provider bills.	for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	Same as In- <a href="#">Network</a>	\$30/visit <a href="#">deductible</a> does not apply	Not covered	Other cost shares may apply depending on services provided. Virtual visits (Telehealth) benefits available.
	<a href="#">Specialist</a> visit	Same as In- <a href="#">Network</a>	\$60/visit <a href="#">deductible</a> does not apply	Not covered	Other cost shares may apply depending on services provided. Virtual visits (Telehealth) benefits available.
	<a href="#">Preventive care</a> / <a href="#">screening</a> /immunization	Same as In- <a href="#">Network</a>	No charge	Not covered	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Same as In- <a href="#">Network</a>	No charge	Not covered	-----none-----
	Imaging (CT/PET scans, MRIs)	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Not covered	-----none-----
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthe">http://www.anthe</a>	Tier 1 - Typically Generic	\$15/prescription, Prescription Drug <a href="#">deductible</a> does not apply (retail) and \$30.00/prescription, Prescription Drug <a href="#">deductible</a> does not apply (home delivery)	\$25/prescription, Prescription Drug <a href="#">deductible</a> does not apply (retail only)	Not covered (retail and home delivery)	Precertification may be required for certain <a href="#">Prescription Drugs</a> . Please note that certain <a href="#">Specialty Drugs</a> are only available from the <a href="#">Specialty Pharmacy</a> and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. For more

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
<a href="http://www.anthem.com/pharmacyinformation/">m.com/pharmacyinformation/</a>	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	\$50/prescription, Prescription Drug <a href="#">deductible</a> applies (retail) and \$125/prescription, Prescription Drug <a href="#">deductible</a> applies (home delivery)	\$60/prescription, Prescription Drug <a href="#">deductible</a> applies (retail only)	Not covered (retail and home delivery)	information, refer to “Essential Drug List” at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a> *See Prescription Drug Section of your evidence of coverage, available in the footnote below.
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	\$75/prescription, Prescription Drug <a href="#">deductible</a> applies (retail) and \$187.50/prescription, Prescription Drug <a href="#">deductible</a> applies (home delivery)	\$85/prescription, Prescription Drug <a href="#">deductible</a> applies (retail only)	Not covered (retail and home delivery)	
	Tier 4 - Typically Preferred Specialty (brand and generic)	30% <a href="#">coinsurance</a> up to \$350/prescription, Prescription Drug <a href="#">deductible</a> applies (retail and home delivery)	30% <a href="#">coinsurance</a> up to \$500/prescription, Prescription Drug <a href="#">deductible</a> applies (retail only)	Not covered (retail and home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Not covered	-----none-----
	Physician/surgeon fees	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Not covered	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Emergency medical transportation</a>	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
	<a href="#">Urgent care</a>	Same as In- <a href="#">Network</a>	\$60/visit <a href="#">deductible</a> does not apply	Covered as In- <a href="#">Network</a>	Other cost shares may apply depending on services provided.
If you have a hospital stay	Facility fee (e.g., hospital room)	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Not covered	150 days/benefit period for Inpatient rehabilitation and skilled nursing services combined for In- <a href="#">Network Providers</a> .
	Physician/surgeon fees	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Not covered	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Same as In- <a href="#">Network</a>	Office Visit \$30/visit <a href="#">deductible</a> does not apply Other Outpatient No charge	Office Visit Not covered Other Outpatient Not covered	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Not covered	-----none-----
If you are pregnant	Office visits	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Not covered	
	Childbirth/delivery facility services	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Not covered	100 visits/benefit period for Home Health and Private Duty Nursing combined In- <a href="#">Network Providers</a> .
	<a href="#">Rehabilitation services</a>	Same as In- <a href="#">Network</a>	\$30/visit <a href="#">deductible</a> does not apply	Not covered	20 visits each for Physical, Speech and Occupational therapy/benefit period for In- <a href="#">Network Providers</a> .

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level 1 Pharmacy- RX Only (You will pay the least)	In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
	<a href="#">Habilitation services</a>	Same as In- <a href="#">Network</a>	\$30/visit <a href="#">deductible</a> does not apply	Not covered	Habilitation visits count towards your rehabilitation limit.
	<a href="#">Skilled nursing care</a>	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Not covered	150 days/benefit period for Inpatient rehabilitation and skilled nursing services combined for In- <a href="#">Network Providers</a> .
	<a href="#">Durable medical equipment</a>	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Not covered	*See <a href="#">Durable Medical Equipment</a> Section
	<a href="#">Hospice services</a>	Same as In- <a href="#">Network</a>	30% <a href="#">coinsurance</a>	Not covered	-----none-----
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Applicable	No charge	Not covered	*See Vision Services Section of your evidence of coverage, available in the footnote below.
	Children's glasses	Not covered	Not covered	Not covered	*See Vision Services Section of your evidence of coverage, available in the footnote below.
	Children's dental check-up	Not covered	Not covered	Not covered	-----none-----

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Dental care (Pediatric)</li> <li>• Hearing aids (18+)</li> <li>• <a href="#">Preauthorization</a> - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. Contact us to find out what must be preauthorized and whether <a href="#">preauthorization</a> has been given.</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental Check-up</li> <li>• Long-term care</li> <li>• Routine foot care unless you have been diagnosed with diabetes</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Adult)</li> <li>• Glasses for a child</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Weight loss programs</li> </ul>

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

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

- Acupuncture 20 visits/benefit period combined with Massage Therapy
- Private-duty nursing 100 visits/benefit period combined with Home Health
- Chiropractic care 20 visits/benefit period
- Routine eye care (Adult) 1 exam/benefit period
- Infertility treatment

**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: Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or contact Anthem at the number on the back of your ID card. 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 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, 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**

[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](#).

*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/>.

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		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	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$60	■ <a href="#">Specialist copayment</a>	\$60	■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	30%	■ Hospital (facility) <a href="#">coinsurance</a>	30%	■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	0%	■ Other <a href="#">coinsurance</a>	0%	■ Other <a href="#">coinsurance</a>	0%
<p>This EXAMPLE event includes services like:</p> <p><a href="#">Specialist</a> office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)  <a href="#">Specialist</a> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Primary care physician</a> office visits (<i>including disease education</i>)  <a href="#">Diagnostic tests</a> (<i>blood work</i>)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Emergency room care</a> (<i>including medical supplies</i>)  <a href="#">Diagnostic test</a> (<i>x-ray</i>)  <a href="#">Durable medical equipment</a> (<i>crutches</i>)  <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,000	<a href="#">Deductibles</a>	\$200	<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$10	<a href="#">Copayments</a>	\$1,600	<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$2,700	<a href="#">Coinsurance</a>	\$0	<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,770</b>	<b>The total Joe would pay is</b>	<b>\$1,820</b>	<b>The total Mia would pay is</b>	<b>\$2,300</b>

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 (877) 811-3106

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በገና የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (877) 811-3106 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 (877) 811-3106.

**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՝ (877) 811-3106:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄édjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̀ bídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̄á (877) 811-3106.

**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 (877) 811-3106 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (877) 811-3106 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(877) 811-3106。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yä thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (877) 811-3106.

**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 (877) 811-3106.

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