




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/](http://www.healthcare.gov/sbc-glossary/) or call (877) 814-9709 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$3,000/person or \$6,000/family for <a href="#">Tier 1 HealthSync Preferred Network Providers</a> . \$3,500/person or \$7,000/family for <a href="#">Tier 2 Network Providers</a> . \$3,500/person or \$7,000/family for Non- <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 policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> for In- <a href="#">Network</a> and Out-of- <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> ?	\$4,500/person or \$9,000/family for <a href="#">Tier 1 HealthSync Preferred Network Providers</a> . \$5,000/person or \$10,000/family for <a href="#">Tier 2 Network Providers</a> . \$5,000/person or \$10,000/family for Non- <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 on the policy, the overall family <a href="#">out-of-pocket limit</a> must be met before the <a href="#">plan</a> begins to pay.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Services deemed not medically necessary by Medical Management and/or Anthem, Out-of- <a href="#">Network</a> Transplant Services, <a href="#">Premiums</a> , <a href="#">balance-</a>	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

	<a href="#">billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes, HealthSync and National PPO (Blue Card PPO). See <a href="http://www.anthem.com">www.anthem.com</a> or call (877) 814-9709 for a list of <a href="#">network providers</a> .	You pay the least if you use a <a href="#">provider</a> in Tier 1 HealthSync. You pay more if you use a <a href="#">provider</a> in Tier 2 In- <a href="#">Network</a> . You will pay the most if you use Teir 3 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.
<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
		Tier 1 HealthSync (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Tier 3 Out-of-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	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care/screening/immunization</a>	No change	No charge	50% <a href="#">coinsurance deductible</a> does not apply	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)	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you need drugs to treat your illness or condition	Tier 1 - Typically Generic	\$10/prescription (retail) and \$20/prescription (CVS Mail Order)	\$10/prescription (retail) and \$20/prescription (CVS Mail Order)	Not covered	Pharmacy Benefit Management Services are provided by CVS Caremark.

\* 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
		Tier 1 HealthSync (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Tier 3 Out-of-Network Provider (You will pay the most)	
More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Tier 2 - Typically <a href="#">Preferred</a> / Brand	\$30/prescription or 20% <a href="#">coinsurance</a> , whichever is greater up to \$50 maximum /prescription (retail) and \$60/prescription or 20% <a href="#">coinsurance</a> , whichever is greater up to \$100 maximum /prescription (CVS Mail Order)	\$30/prescription or 20% <a href="#">coinsurance</a> , whichever is greater up to \$50 maximum /prescription (retail) and \$60/prescription or 20% <a href="#">coinsurance</a> , whichever is greater up to \$100 maximum /prescription (CVS Mail Order)	Not covered	Up to a 90 day supply is available at CVS Caremark Mail Order Pharmacy or at participating Retail Pharmacy Locations.
	Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a>	\$50/prescription or 40% <a href="#">coinsurance</a> , whichever is greater up to \$70 maximum /prescription (retail) and \$100/prescription or 40% <a href="#">coinsurance</a> , whichever is greater up to \$140 maximum /prescription (CVS Mail Order)	\$50/prescription or 40% <a href="#">coinsurance</a> , whichever is greater up to \$70 maximum /prescription (retail) and \$100/prescription or 40% <a href="#">coinsurance</a> , whichever is greater up to \$140 maximum /prescription (CVS Mail Order)	Not covered	
	Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)	\$75/prescription or 40% <a href="#">coinsurance</a> , whichever is	\$75/prescription or 40% <a href="#">coinsurance</a> , whichever is greater up to \$150	Not covered	

\* 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
		Tier 1 HealthSync (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Tier 3 Out-of-Network Provider (You will pay the most)	
		greater up to \$150 maximum /prescription (retail) and \$75/prescription or 40% <a href="#">coinsurance</a> , whichever is greater up to \$150 maximum /prescription (CVS Mail Order)	maximum /prescription (retail) and \$75/prescription or 40% <a href="#">coinsurance</a> , whichever is greater up to \$150 maximum /prescription (CVS Mail Order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% coinsurance	10% <a href="#">coinsurance</a>	Covered as In-Network	-----none-----
	<a href="#">Emergency medical transportation</a>	10% coinsurance	10% <a href="#">coinsurance</a>	Covered as In-Network	-----none-----
	<a href="#">Urgent care</a>	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 10% coinsurance Other Outpatient 10% coinsurance	Office Visit 30% <a href="#">coinsurance</a> Other Outpatient 30% <a href="#">coinsurance</a>	Office Visit 50% <a href="#">coinsurance</a> Other Outpatient 50% <a href="#">coinsurance</a>	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If you are pregnant	Office visits	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need help recovering or have	<a href="#">Home health care</a>	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Rehabilitation services</a>	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	*See Therapy Services section

\* 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
		Tier 1 HealthSync (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Tier 3 Out-of-Network Provider (You will pay the most)	
other special health needs	<a href="#">Habilitation services</a>	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	100 days limit/benefit period.
	<a href="#">Durable medical equipment</a>	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	*See <a href="#">Durable Medical Equipment</a> Section
	<a href="#">Hospice services</a>	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----none-----
If your child needs dental or eye care	Children's eye exam	10% coinsurance	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	*See Vision Services section
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	*See Dental Services section

### 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](#).)

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

**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 the home. 82 visits/benefit period. 164 visits/lifetime.
- Chiropractic care 12 visits/benefit period.
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.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 Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://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](http://www.HealthCare.gov) or call 1-800-318-2596.

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

**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

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov)

**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/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.

### 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>	\$3,500
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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	\$12,700
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,000</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>	\$3,500
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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	\$5,600
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$3,500
<a href="#">Copayments</a>	\$80
<a href="#">Coinsurance</a>	\$630
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$4,210</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>	\$3,500
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

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	\$2,800
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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





## Language Access Services:

**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 (877) 814-9709.

**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 (877) 814-9709.

**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 (877) 814-9709.

**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 (877) 814-9709.

**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 (877) 814-9709 ।

**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 (877) 814-9709.

**Igbo (Igbo):** O bur u na i nwere ajuju o bula gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o bula. Ka gi na okowa okwu kwuo okwu, kpoo (877) 814-9709.

**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 (877) 814-9709.

**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 (877) 814-9709.

**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 (877) 814-9709

**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、(877) 814-9709 にお電話ください。

## Language Access Services:

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។  
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ (877) 814-9709 ។

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (877) 814-9709.

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (877) 814-9709 로 문의하십시오.

**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.  
ເພື່ອໂອ້ນລຳບວກວ່າມແບພາສາ, ໃຫ້ໂທຫາ (877) 814-9709.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idiilkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjì bee nił hodoonih t'áadoo báąh ilinígóó.  
Ata' halne'ígíí la' bich'i' hadeesdzih nínízingo kojì' hodiilnih (877) 814-9709.

**Nepali (नेपाली):** यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।  
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## Language Access Services:

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