



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 at www.healthcare.gov/sbc-glossary/ or call (855) 255-9952 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$3,000/person or \$5,400/family for In-Network Providers. \$2,800/person or \$5,400/family for Non-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 (embedded). Deductible resets January 1.
Are there services covered before you meet your deductible?	Yes. Preventive Care 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?	\$3,000/person or \$5,400/family for In-Network Providers. \$3,700/person or \$7,400/family for Non-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 (855) 255-9952 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

	<u>providers</u> .	<u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>Out-of-Network Provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	<u>Specialist</u> visit	0% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
If you have a test	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Costs may vary by site of service.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com .	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Costs may vary by site of service.
	Tier 1 - Typically Generic	0% <u>coinsurance</u> for Retail & Home Delivery	Not covered	Provider means pharmacy for purposes of this section. Retail: Up to a 30-day supply Mail-Order: Up to a 90-day supply
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	0% <u>coinsurance</u> for Retail & Home Delivery	Not covered	You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Notification requirement or may result in a higher cost. If you use a non-network Pharmacy, you are responsible for any amount over the allowed amount. You may be required to use a lower-cost
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	0% <u>coinsurance</u> for Retail & Home Delivery	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
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Tier 4 - Typically Preferred Specialty (brand and generic)	0% coinsurance Home Delivery, 30 day limit	Not covered	drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 Contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	-----none-----
	Physician/surgeon fees	0% coinsurance	40% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	0% coinsurance	Covered as In-Network	-----none-----
	Emergency medical transportation	0% coinsurance	Covered as In-Network	Non-emergency non-network Ambulance Services are limited to \$50,000 per trip.
If you have a hospital stay	Urgent care	0% coinsurance	40% coinsurance	-----none-----
	Facility fee (e.g., hospital room)	0% coinsurance	40% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Physician/surgeon fees	0% coinsurance	40% coinsurance	-----none-----
	Outpatient services	Office Visit 0% coinsurance Other Outpatient 0% coinsurance	Office Visit 40% coinsurance Other Outpatient 40% coinsurance	Office Visit -----none----- Other Outpatient -----none-----
If you are pregnant	Inpatient services	0% coinsurance	40% coinsurance	-----none-----
	Office visits	0% coinsurance	40% coinsurance	-----none-----
If you need help recovering or have other special health needs	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	-----none-----
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	-----none-----
	Rehabilitation services	0% coinsurance	40% coinsurance	Costs may vary by site of service.
	Habilitation services	0% coinsurance	40% coinsurance	*See Therapy Services section.
	Skilled nursing care	0% coinsurance	40% coinsurance	-----none-----
	Durable medical equipment	0% coinsurance	40% coinsurance	*See Durable Medical Equipment Section
If you need help recovering or have other special health needs	Hospice services	0% coinsurance	40% coinsurance	-----none-----
	Children's eye exam	0% coinsurance	40% coinsurance	*See Vision Services section

* 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>.

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 your child needs dental or eye care	Children's glasses	Not covered	Not covered	-----none-----
	Children's dental check-up	Not covered	Not covered	

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 care (Adult)
- Glasses for a child
- Routine foot care
- Bariatric surgery
- Dental care (Pediatric)
- Infertility treatment
- Weight loss programs
- Cosmetic surgery
- Dental Check-up
- Long-term care

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

- Chiropractic care 24 visits/benefit period
- Private-duty nursing in a Home Setting only
- Hearing aids 1 Item/ear every 3 years,
- Routine eye care (Adult)
- \$2,500 maximum/benefit period
- Most coverage provided outside the United States. See www.bcbsglobalcare.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: Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (800) 686-1526, (614) 644-2673, 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

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

Does this plan provide Minimum Essential Coverage? Yes/No

[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](#).

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

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)

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 plan's overall deductible \$2,800
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

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- 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)

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)

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	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,860

Total Example Cost	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,820

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$00
The total Mia would pay is	\$2,800

The plan would be responsible for the other costs of these EXAMPLE covered services.