



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/fi>. 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) 333-5735 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<b>\$2,500</b> /single or <b>\$5,000</b> /family for In- <a href="#">Network Providers</a> . <b>\$5,000</b> /single or <b>\$10,000</b> /family for Out-of- <a href="#">Network Providers</a> . This HRA account reimburses you for certain deductibles and coinsurance amounts up to <b>\$400</b> /single or <b>\$1,150</b> /family.	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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <a href="#">Prescription Drugs</a> , <a href="#">Preventive care</a> , Primary Care visit, <a href="#">Specialist</a> visit, and Vision exam for In- <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> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<b>\$3,750</b> /single or <b>\$7,500</b> /family for In- <a href="#">Network Providers</a> . <b>\$7,500</b> /single or <b>\$15,000</b> /family for Out-of- <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.
<b>What is not included in the out-of-pocket limit?</b>	Non- <a href="#">Network</a> Transplant Services, <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> .
<b>Will you pay less if you use a network provider?</b>	Yes, Blue Access. See <a href="http://www.anthem.com">www.anthem.com</a> or call (855) 333-5735 for a list of <a href="#">network providers</a> .	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 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.



Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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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)	
	Primary care visit to treat an injury or illness	\$25/visit <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Specialist</a> visit	\$50/visit <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a>	No charge	30% <a href="#">coinsurance</a>	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)	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
	Tier 1 - Typically Generic	\$10/prescription <a href="#">deductible</a> does not apply (retail and home delivery)	\$75/prescription or 50% <a href="#">coinsurance</a> , whichever is greater (retail)	*See Prescription Drug section
	Tier 2 - Typically Preferred / Brand	\$30/prescription <a href="#">deductible</a> does not apply (retail) and \$75/prescription <a href="#">deductible</a> does not apply (home delivery)	\$75/prescription or 50% <a href="#">coinsurance</a> , whichever is greater (retail)	
	Tier 3 - Typically Non-Preferred / <a href="#">Specialty Drugs</a>	\$50/prescription <a href="#">deductible</a> does not apply (retail) and \$150/prescription <a href="#">deductible</a> does not apply (home delivery)	\$75/prescription or 50% <a href="#">coinsurance</a> , whichever is greater (retail)	
	Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)	25% <a href="#">coinsurance</a> up to \$200/prescription <a href="#">deductible</a> does not apply (retail) and 25% <a href="#">coinsurance</a> up to \$200/prescription <a href="#">deductible</a> does not apply	\$75/prescription or 50% <a href="#">coinsurance</a> , whichever is greater (retail)	

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

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)	
		(home delivery)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Physical medicine and rehabilitation services (including day rehabilitation programs) are limited to 60 days of care regardless of the <a href="#">provider's network</a> status.
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$25/visit <a href="#">deductible</a> does not apply Other Outpatient 0% <a href="#">coinsurance</a>	Office Visit 30% <a href="#">coinsurance</a> Other Outpatient 30% <a href="#">coinsurance</a>	Office Visit -----none----- Other Outpatient -----none-----
	Inpatient services	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
If you are pregnant	Office visits	\$25/visit <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	100 visits/benefit period. Limit does not include I.V. therapy.
	<a href="#">Rehabilitation services</a>	\$25/visit <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	*See Therapy Services section
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	100 day limit/benefit period.
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	-----none-----
If your child needs dental or eye care	Children's eye exam	\$25/visit <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	*See Vision Services section
	Children's glasses	Not covered	Not covered	

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

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)	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

### Excluded Services & Other Covered Services:

<ul style="list-style-type: none"> <li>• Abortion</li> <li>• Cosmetic surgery</li> <li>• Glasses for a child</li> <li>• Long- term care</li> <li>• Spinal Manipulation</li> </ul>	<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Dental care (adult)</li> <li>• Hearing aids except every three years for members under 18 years of age</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Weight loss programs</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Dental Check-up</li> <li>• Infertility treatment</li> <li>• Routine foot care unless you have been diagnosed with diabetes.</li> </ul>
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<ul style="list-style-type: none"> <li>• Private-duty nursing 82 visits/benefit period. 164 visits/lifetime.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (adult)</li> </ul>
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**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 Insurance, 215 West Main Street, Frankfort, Kentucky 40601, (502) 564-3630, (800) 595-6053, (800) 648-6056. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://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](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 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 Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, (502) 564-3630, (800) 595-6053, (800) 648-6056

### Does this plan provide Minimum Essential Coverage? Yes

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

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

from the requirement that you have health coverage for that month.

**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](#).

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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

About these Coverage Examples:



- The [plan's overall deductible](#) \$2,500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 0%
- Other [copayment](#) \$0

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- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 0%
- Other [copayment](#) \$0

- The [plan's overall deductible](#) \$2,500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 0%
- Other [copayment](#) \$0

This EXAMPLE event includes services like:

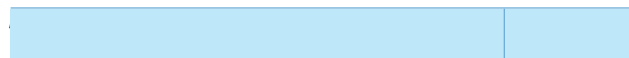
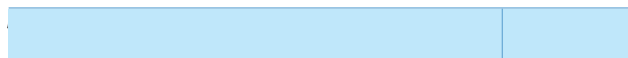
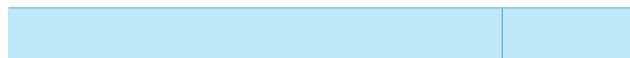
- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

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*)



In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$90
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,650</b>

In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,728
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,783</b>

In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,416
<a href="#">Copayments</a>	\$250
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,666</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 (855) 333-5735

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 333-5735 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 (855) 333-5735.

**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՝ (855) 333-5735:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè bɛ̀ bédé bá céè-djè nìà ke dyí ní, ɔ̀ m̀ò nì dyí-bédjèin-djè bɛ̀ m̀ ké gbo-kpá-kpá kè b̄́ kp̄́ djé m̀ bídí-wùdùùn b̀ó pídyi. Bɛ̀ m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̀á (855) 333-5735.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 333-5735 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (855) 333-5735 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 (855) 333-5735。

**Dinka (Dinka):** Na nɔŋ thiëc nē ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wēr alēu bē gɛɛr yic yin ne thoŋ du ke cin wēu tāäuē ke piny. Te kɔr yin ba jam wēnē ran ye thok geryic, ke yin cɔl (855) 333-5735.

**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) 333-5735.

**Farsi (فارسی):** در صورتی که سؤالی 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 مترجم شفاهی، با شماره (855) 333-5735 تماس بگیرید.

**French (Français):** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 333-5735.

## 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 (855) 333-5735.

**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 (855) 333-5735.

**Gujarati (ગુજરાતી):** જો તમને આ દસ્તાવેજ વિશે કોઈ પ્રશ્ન હોય, તો તમને મફત મદદ અને માહિતી આપવામાં આવશે. મદદ માટે અથવા માહિતી માટે કોઈ ભાષામાં કોઈ વ્યક્તિ સાથે વાત કરવા માટે, કૃપા કરીને (855) 333-5735 નંબર પર કોલ કરો.

**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 (855) 333-5735.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको नि:शुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 333-5735 ।

**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 (855) 333-5735.

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