




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/ or call (833) 592-9954 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall <u>deductible</u>? | \$4,500/person or \$9,000/family for <u>In-Network Providers</u> . \$5,000/person or \$10,000/family for <u>Out-of-Network Providers</u> . | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u>? | Yes. <u>Preventive Care</u> . For more information see below. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | \$7,000/person or \$14,000/family for <u>In-Network Providers</u> . \$7,500/person or \$15,000/family for <u>Out-of-Network Providers</u> . | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u>? | <u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Will you pay less if you use a <u>network provider</u>? | Yes. See www.anthem.com/find-care/?alphaprefix=AKH or call (833) 592-9954 for a list of <u>network providers</u> . Benefits and costs may vary by site of service and how the <u>provider</u> bills. | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>Out-of-Network Provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <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 referral to see a specialist ? | 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) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Virtual visits (Telehealth) benefits available. |
| | <u>Specialist</u> visit | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Virtual visits (Telehealth) benefits available. |
| | <u>Preventive care</u> / <u>screening</u> /immunization | No charge | 30% <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. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | -----none----- |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | -----none----- |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.[insert]. | Typically Generic (Tier 1) | 20% coinsurance | Not covered (retail and home delivery) | Once the Out-of-Pocket maximum has been met, prescription drug shall be covered at 100% for the remainder of the calendar year. Covers up to a 34-day supply (retail prescription); 90-day supply (mail orders or Smart90 retail prescription). Certain prescriptions shall be covered at 100%, and no co-pay will apply as per Federal Regulations. Patient must pay the cost difference between the brand and generic drug in addition to your copay or coinsurance. * Copays for certain specialty prescription drugs considered non-essential health benefits under the plan bypass your out-of-pocket limit. Please see "Important Questions" regarding the plan's out-of-pocket limit. See Plan Documents for additional information on the SaveonSP Program. Out-of-Network RX reimbursed at 100% minus applicable copayment by filing RX claim form. |
| | Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2) | 20% coinsurance | Not covered (retail and home delivery) | |
| | Typically Non-Preferred Brand and Generic drugs (Tier 3) | 20% coinsurance | Not covered (retail and home delivery) | |
| | Typically Preferred <u>Specialty</u> (brand and generic) (Tier 4) | 20% coinsurance | Not covered (retail and home delivery) | |

* For more information about limitations and exceptions, see the 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) | Out-of-Network Provider (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | -----none----- |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | -----none----- |
| If you need immediate medical attention | <u>Emergency room care</u> | 20% <u>coinsurance</u> | Covered as In- <u>Network</u> | -----none----- |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | Covered as In- <u>Network</u> | -----none----- |
| | <u>Urgent care</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Services must be pre-certified in order to avoid a 50% penalty up to a maximum penalty of \$500 per occurrence. |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | -----none----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit 20% <u>coinsurance</u> Other Outpatient 20% <u>coinsurance</u> | Office Visit 30% <u>coinsurance</u> Other Outpatient 30% <u>coinsurance</u> | Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none----- |
| | Inpatient services | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | -----none----- |
| If you are pregnant | Office visits | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | -----none----- |
| | <u>Rehabilitation services</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | *See Therapy Services section. |
| | <u>Habilitation services</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | 60 days/benefit period for skilled nursing services. |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | *See <u>Durable Medical Equipment</u> section. |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Life expectancy up to 12 months. |
| If your child needs dental or eye care | Children's eye exam | No charge, up to age 19 | 30% <u>coinsurance</u> | -----none----- |
| | Children's glasses | Not covered | Not covered | |
| | Children's dental check-up | Not covered | Not covered | -----none----- |

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

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 | • Children's dental check-up | • Cosmetic surgery |
| • Dental care (Adult) | • Eye exams for a child | • Glasses for a child |
| • Hearing aids | • Infertility treatment | • Long-term care |
| • Routine eye care (Adult) | • Routine foot care | • Weight loss programs |

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

- | | | |
|---|--|--|
| • Bariatric surgery | • Chiropractic care 62 visits/benefit period combined with all other therapies | • Most coverage provided outside the United States. See www.bcbsglobalcore.com |
| • Private-duty nursing in a Home Setting only | | |

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.ccio.cms.gov, 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 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, 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.ccio.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/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.

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 <u>deductible</u> | \$4,500 | ■ The plan's overall <u>deductible</u> | \$4,500 | ■ The plan's overall <u>deductible</u> | \$4,500 |
| ■ <u>Specialist coinsurance</u> | 20% | ■ <u>Specialist coinsurance</u> | 20% | ■ <u>Specialist coinsurance</u> | 20% |
| ■ <u>Hospital (facility) coinsurance</u> | 20% | ■ <u>Hospital (facility) coinsurance</u> | 20% | ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other coinsurance</u> | 20% | ■ <u>Other coinsurance</u> | 20% | ■ <u>Other coinsurance</u> | 20% |
| This EXAMPLE event includes services like: <u>Specialist office visits</u> (<i>prenatal care</i>) <u>Childbirth/Delivery Professional Services</u> <u>Childbirth/Delivery Facility Services</u> <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist visit</u> (<i>anesthesia</i>) | | This EXAMPLE event includes services like: <u>Primary care physician office visits</u> (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>) | | This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>) | |
| Total Example Cost | | Total Example Cost | | Total Example Cost | |
| \$12,700 | | \$5,600 | | \$2,800 | |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| <u>Cost Sharing</u> | | <u>Cost Sharing</u> | | <u>Cost Sharing</u> | |
| <u>Deductibles</u> | \$4,500 | <u>Deductibles</u> | \$1,100 | <u>Deductibles</u> | \$2,800 |
| <u>Copayments</u> | \$0 | <u>Copayments</u> | \$0 | <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$1,600 | <u>Coinsurance</u> | \$0 | <u>Coinsurance</u> | \$0 |
| <u>What isn't covered</u> | | <u>What isn't covered</u> | | <u>What isn't covered</u> | |
| Limits or exclusions | \$70 | Limits or exclusions | \$4,300 | Limits or exclusions | \$10 |
| The total Peg would pay is | | The total Joe would pay is | | The total Mia would pay is | |
| \$6,170 | | \$5,400 | | \$2,810 | |

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

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòm nan dokiman sa a.

Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجاًاً. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضاً طلب تنسيقات أخرى لهذه الوثيقة.

French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください。視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>