

 <p>The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. <b>NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary.</b> For more information about your coverage, or to get a copy of the complete terms of coverage, <a href="https://eoc.anthem.com/eocdps/8F3ASMG01012025">https://eoc.anthem.com/eocdps/8F3ASMG01012025</a>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <a href="http://www.healthcare.gov/sbc-glossary/">www.healthcare.gov/sbc-glossary/</a> or call (855) 330-1214 to request a copy.</p>		
Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$3,000/person or \$6,000/family for In-Network Providers. \$7,500/person or \$15,000/family for Out-of-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible 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 deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
<b>Are there services covered before you meet your deductible?</b>	Yes. Primary Care. Specialist Visit. Preventive Care. Vision. For more information see below.	This <u>plan</u> covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost sharing</u> and before you meet your deductible. 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>	Yes. \$250/person or \$500/family for Prescription Drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	\$5,500/person or \$11,000/family for In-Network Providers. \$13,750/person or \$27,500/family for Out-of-Network Providers.	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.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billing charges, health care this <u>plan</u> doesn't cover, and Out-of-Network Transplants.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.anthem.com/find-care/?alphabetical=Z6U">www.anthem.com/find-care/?alphabetical=Z6U</a> or call (855) 330-1214 for a list of network providers. Costs may	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 charge</u> 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.

	vary by site of service and how the <u>provider</u> bills.	
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	EPHC \$25/visit, <u>deductible</u> does not apply PCP \$35/visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Copayment</u> waived for members under 19 years old. Virtual visits (Telehealth) benefits available.
	<u>Specialist</u> visit	\$55/visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	Virtual visits (Telehealth) benefits available.
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge	50% <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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a>	Typically Generic (Tier 1)	\$15/prescription, Prescription Drug <u>deductible</u> does not apply (retail) and \$30/prescription, Prescription Drug <u>deductible</u> does not apply (home delivery)	50% <u>coinsurance</u> , Prescription Drug <u>deductible</u> does not apply (retail) and Not covered (home delivery)	For more information, refer to "Select Drug List" at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a> *See Prescription Drug section.
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	\$45/prescription, Prescription Drug <u>deductible</u> applies (retail) and \$113/prescription, Prescription Drug <u>deductible</u> applies (home delivery)	50% <u>coinsurance</u> , Prescription Drug <u>deductible</u> applies (retail) and Not covered (home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	25% <u>coinsurance</u> up to \$200/prescription, Prescription Drug <u>deductible</u> applies (retail) and 25% applies (retail) and 25%	50% <u>coinsurance</u> , Prescription Drug <u>deductible</u> applies (retail) and Not covered (home delivery)	

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/8F3ASMG01012025>.

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)	
		<u>coinsurance</u> up to \$500/prescription, Prescription Drug deductible applies (home delivery)		
	Typically Preferred Specialty (brand and generic) (Tier 4)	25% <u>coinsurance</u> up to \$400/prescription, Prescription Drug deductible applies (retail and home delivery)	50% <u>coinsurance</u> , Prescription Drug deductible applies (retail) and Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	\$350/visit	Covered as In-Network	<u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Covered as In-Network	Non-emergency <u>Out-of-Network</u> Ambulance Services are limited to \$50,000 per trip, does not apply to air ambulance.
	<u>Urgent care</u>	\$55/visit, deductible does not apply	50% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	100 days/admission for Inpatient rehabilitation and skilled nursing services combined.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$35/visit, deductible does not apply Other Outpatient 20% <u>coinsurance</u>	Office Visit 50% <u>coinsurance</u> Other Outpatient 50% <u>coinsurance</u>	Office Visit <u>Copayment</u> waived for members under 19 years old. Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you are pregnant	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	100 visits/benefit period.

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/8F3ASMG01012025>.

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)	
recovering or have other special health needs	<u>Rehabilitation services</u>	\$35/visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	*See Therapy Services section.
	<u>Habilitation services</u>	\$35/visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	
If your child needs dental or eye care	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	100 days/admission for Inpatient rehabilitation and skilled nursing services combined.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	*See <u>Durable Medical Equipment</u> section.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Children's eye exam	No charge	Not covered	
	Children's glasses	No charge	\$0 <u>copayment</u> up to <u>plan's Maximum Allowed Amount</u>	*See Vision Services section.
Children's dental check-up	0% <u>coinsurance</u>	30% <u>coinsurance</u>	*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 care (Adult)
- Routine foot care unless medically necessary
- Bariatric surgery
- Infertility treatment
- Weight loss programs
- Cosmetic surgery
- 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 30 visits/benefit period
- Private-duty nursing 16 hours/benefit period in a Home Setting only
- Hearing aids 1 item/ear every 24 months for children 18 years of age or under. \$1,500 maximum/hearing aid.
- Routine eye care (Adult) 1 exam/benefit period
- Most coverage provided outside the United States. See [www.bcbsglobalcare.com](http://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: Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945, 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.

\* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/8F3ASMG01012025>.

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, P.O. Box 27401, Richmond, VA 23279

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945

**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.*

**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 plan's overall deductible \$3,000
- Specialist copayment \$55
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**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

**In this example, Peg would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,970</b>

**Managing Joe's Type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$3,000
- Specialist copayment \$55
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**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

**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$1,500
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,920</b>

**Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$3,000
- Specialist copayment \$55
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**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

**In this example, Mia would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,100
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,400</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 merreni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (855) 330-1214

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቁጥቁ አርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 330-1214 ይደውሉ።

. (855) 330-1214 على اتصال مع مترجم، للتحدث إلى مترجم. مقابل. للمعلومات بلغتك دون مقابل. (العربية) Arabic

**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) 330-1214:

**Bassa (Bässò wùdù):** M̄ d̄yí d̄yí-diè-d̄è b̄é b̄édé b̄á céé-d̄è nià ke d̄yí ní, ɔ mò ni d̄yí-b̄édèin-d̄è b̄é m̄ ké gbo-kpá-kpá kè b̄ǒ kpǒ d̄é m̄ b̄idj-wùdùùn b̄ó pídyi. B̄é m̄ ké wudu-zìin-nyò d̄ò gbo wùdù ke, d̄á (855) 330-1214.

**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) 330-1214 - (ত কল করুন)

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် (855) 330-1214 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) 330-1214。

**Dinka (Dinka):** Na noŋ thiéc né ke de yá thoŋ, ke yin noŋ loŋ bē yi kuony ku wer alēu bē gēer yic yin ne thoŋ du ke cin wēu tāauē ke piny. Te kōr yin ba jam wēnē ran ye thok geryic, ke yin col (855) 330-1214.

**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) 330-1214.

**Farsi (فارسی):** در صورتی که سؤالی بپرسید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادرتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره تماس (855) 330-1214

## Language Access Services:

**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) 330-1214.

**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) 330-1214.

**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) 330-1214.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષયિ સાથે વાત કરવા માટે, કોલ કરો (855) 330-1214.

**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) 330-1214.

**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 (855) 330-1214 ।

**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) 330-1214.

**Igbo (Igbo):** O bur u na i nwere ajuju o buła gbasara akwukwọ a, i nwere ikike inweta enyemaka na ozi n'asụsụ gi na akwughị ugwo o buła. Ka gi na okwọwa okwu kwuo okwu, kpọọ (855) 330-1214.

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ເພື່ອໄດ້ຮັບກັບວ່າມເປັນພາສາ, ໃຫ້ໂທຫາ (855) 330-1214.

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