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/eocdp5/](https://eoc.anthem.com/eocdp5/). 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 (833) 592-9956 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$1,500/person or $3,000/family for In-Network Providers, $3,000/person or $6,000/family for Non-Network Providers.</td>
<td>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 policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive Care for In-Network Providers, Vision for In-Network and Non-Network Providers.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$3,750/person, $6,650/person in a family, or $7,500/family for In-Network Providers. $7,500/person, $7,500/person in a family, or $12,000/family for Non-Network Providers.</td>
<td>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, the overall family out-of-pocket limit must be met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes, KeyCare. See <a href="http://www.anthem.com">www.anthem.com</a> or call (833) 592-9956 for a list of network providers.</td>
<td>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 plan pays (balance billing). Be aware your network provider might use an Out-of-Network Provider for some services (such as lab work). Check with your provider before you get...</td>
</tr>
</tbody>
</table>
Do you need a **referral** to see a **specialist**?

No. You can see the **specialist** you choose without a **referral**.

---

**All copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Non-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>10% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
<td><strong>--------none--------</strong></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>10% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
<td><strong>--------none--------</strong></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>30% <strong>coinsurance</strong></td>
<td>You may have to pay for services that aren't preventive. Ask your <strong>provider</strong> if the services needed are preventive. Then check what your <strong>plan</strong> will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
<td>Costs may vary by site of service.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
<td>Costs may vary by site of service.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 - Typically Generic</td>
<td>20% <strong>coinsurance</strong> (retail) and 15% <strong>coinsurance</strong> (home delivery)</td>
<td>30% <strong>coinsurance</strong> (retail and home delivery)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 2 - Typically Preferred Brand &amp; Non-Preferred Generic Drugs</td>
<td>40% <strong>coinsurance</strong> (retail) and 35% <strong>coinsurance</strong> (home delivery)</td>
<td>30% <strong>coinsurance</strong> (retail and home delivery)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3 - Typically Non-Preferred Brand and Generic drugs</td>
<td>50% <strong>coinsurance</strong> (retail) and 45% <strong>coinsurance</strong> (home delivery)</td>
<td>30% <strong>coinsurance</strong> (retail and home delivery)</td>
<td>*See Prescription Drug section</td>
</tr>
<tr>
<td></td>
<td>Tier 4 - Typically Preferred Specialty (brand and generic)</td>
<td>50% <strong>coinsurance</strong> (retail) and 45% <strong>coinsurance</strong> (home delivery)</td>
<td>30% <strong>coinsurance</strong> (retail and home delivery)</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
<td><strong>--------none--------</strong></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% <strong>coinsurance</strong></td>
<td>30% <strong>coinsurance</strong></td>
<td><strong>--------none--------</strong></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>10% <strong>coinsurance</strong></td>
<td>Covered as In-Network</td>
<td><strong>--------none--------</strong></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% <strong>coinsurance</strong></td>
<td>Covered as In-Network</td>
<td><strong>--------none--------</strong></td>
</tr>
</tbody>
</table>

---

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/fi.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network Provider</strong> (You will pay the least)</td>
<td><strong>Non-Network Provider</strong> (You will pay the most)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td>10% coinsurance</td>
<td></td>
<td>Covered as In-Network</td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>60 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Outpatient services</td>
<td>Office Visit 10% coinsurance</td>
<td>Office Visit 30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>40 visits/benefit period for Home Health and Private Duty Nursing combined.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>*See Therapy Services section.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>60 days/benefit period for Inpatient rehabilitation and skilled nursing services combined.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>*See Durable Medical Equipment Section</td>
</tr>
<tr>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>Reimbursed Up to $30</td>
<td></td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

**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.)**

- Dental care (Adult)
- Bariatric surgery
- Cosmetic surgery

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/eocdps/fi.
• Glasses for a child
• Long-term care
• Dental care (Pediatric)
• Routine foot care unless medically necessary
• Dental Check-up
• Weight loss programs

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

• Chiropractic care
• Routine eye care (Adult) 1 exam/benefit period.
• Acupuncture
• Hearing aids
• Infertility treatment
• Most coverage provided outside the United States. See www.bcbsglobalcore.com
• Private-duty nursing 40 visits/benefit period combined with Home Health

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, 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 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
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.

* For more information about limitations and exceptions, see plan or policy document at https://eoc.anthem.com/coedps/fi.
### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan’s overall deductible**: $1,500
- **Specialist coinsurance**: 10%
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,500</td>
<td>$0</td>
<td>$2,200</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $60 |

The total Peg would pay is $3,760

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

### Managing Joe’s Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible**: $1,500
- **Specialist coinsurance**: 10%
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,500</td>
<td>$0</td>
<td>$800</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $20 |

The total Joe would pay is $2,320

### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan’s overall deductible**: $1,500
- **Specialist coinsurance**: 10%
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,500</td>
<td>$0</td>
<td>$300</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $0 |

The total Mia would pay is $1,800

---

**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.

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Page 5 of 10
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 (833) 592-9956

Amharic (አማርኛ): ከእነስ ሳንquoise የተፈለጉበት ከእምራት ከማት ለሚምር ከማት ከማእለም ከማእለም ከማእለም ከማእለም ከማእለም ከማእለም ከማእለም ከማእለም ከማእለም (833) 592-9956 ይታуч ከማእለም ከማእለም ከማእለም (833) 592-9956

Arabic (العربية): إذا كن لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 9956-592 (833)

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն: Թարգմանչի հետ խոսելու համար զանգահարեք (833) 592-9956:

Bassa (Bãsõ Wùɗù): Ì ṣì jì jì̤d̩í̤-dè̤ jì bë bë̀dë bá cè̀d̩è nìa ke dìjì nì, o mò ni jìd̩í̤-dè̤ jì bë m ke gbo-kpà̤-kpà ke bò kpò bë in bìjì-wùɗṳ̀n bò pìdyì. Ì m ke wùɗṳ̀-ziñ-nyò bò gbo wùɗù ke, dà (833) 592-9956.

Bengali (বাংলা): যদি এই লিখিতের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষার বিলাসুলভ সাহায্য পাওয়া ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলা জন্য (833) 592-9956 –তে কল করুন।

Burmese (ကြမ်း): မြန်မာစိုက်ပျိုင်းထောင်သည်၏ သစ်သီးသား စီးပြဗေဒ ကြက်စီးပြည်နယ်တွင် အခြေခံဆိုရာ မွန်အမွန်စီမံခန့်သိတ်များ၏ အမှတ်အများကို စီးပြဗေဒ (833) 592-9956 ဖျင်ပွဲပြောင်း。“

Chinese (中文)：如果您对本文件有任何疑问，您有权使用您的语言免费获得协助和资讯。如需与译员通电话，请致电(833) 592-9956。

Dinka (Dinka): Na nong thiéec nê ke de ya thore, ke yin nong log bë yi kuony ku wer akë bë gëez yic yin ne thon dë ke cin weu tåau ke piny. Te këy yin ba jam wênce ran ye thok geryc, ke yin col (833) 592-9956.

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 (833) 592-9956.
Language Access Services:

Khmer (ម៉ោង): បញ្ជាក់ចម្លើយខ្មែរដោយក្រុមបណ្តុះខ្មែរដោយអ្នកប្រឃប្បយោគ: សិទ្ធិវិធីប្រឃប្បយោគគ្នានឹងអាចជួយបាននៅក្នុងភាសាប្រុងក្រោយ។ សិទ្ធិនេះប្រឃប្បយោគមកពី (833) 592-9956 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (833) 592-9956.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (833) 592-9956 로 문의하십시오.

Lao (ພາສາລາວ): ຍົງທັບທີ່ມັກິ້ງຮຽກຮຽນການຮຮຽວອະທິບາບີ, ບ້ານມີລິດທະນາສາມາດຮຽວຮຽນ ໃນພິສາດ ເຊິ່ງຮູບຮ້ອງ ໄດ້ຕ້ອງການກື້ນບ້ານຊາຍເທູກໂທລະພາບ. ທ່ານມີໂຄງຄິດພົບພາສາ, ທ່ານທ້າຍ (833) 592-9956.

Navajo (Diné): Díí naaltsoos biká’ígií lahgo bina’dilkidgo ná bohonéedzá dóó bee ahóó’i’ t’aá ni nízaad k’ehjí bee niil hodooíih t’áadoo bááh’ilinígóó. Ata’ halne’ígií la’ bichí’i’ hadeesdzih níniíngo kojí’ hodóólinih (833) 592-9956.

Nepali (नेपाली): यदि आप निर्देशातील पराससंग्रह केल्याचे प्रश्न हून चांगले नसेल, तर आपल्या भाषेतील निश्चित सूचना तथा जाणकारी प्राप्त करणे हे तुकडे पराससंग्रह आहे। दोमाथांनी कुठा गरेला लागि, यांनी कल गुड़गुड़ू (833) 592-9956

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 Yiddish: (אידיש): איברアイראאיטשתילטנער, די שטמעאָטנמונג, הנען אייר די רעכטן צא בָּקָּוצָּט, דעם איינפארטשען איין שפּאָרער אַנד ipadער. צא רעדא. צא

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