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 (800) 810-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,700/single or $3,400/family for In-Network Providers. $3,400/single or $6,800/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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive Care. For more information see below.	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?	$4,000/single or $6,000/family for In-Network Providers. $8,000/single or $12,000/family for Non-Network Providers. Health Savings Account: Access to an HSA is available for eligible participants (not COBRA participants or retirees) when enrolled on this plan. Funding may be used for reimbursements of eligible health expenses. Employee-only level coverage has $450/ annual HSA funding. Employee-plus-one or more coverage tiers have access to	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.

	$900/ annual HSA funding. Visit Fidelity at www.netbenefits.com or call 1-833-252-2244 for additional information.	
What is not included in the out-of-pocket limit?	Premiums, certain specialty drugs managed by Prudent Rx, balance-billing charges, health care this plan doesn't cover, and cost containment penalties (for failure to pre-certify).	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, for a list of in-network providers, see www.anthem.com or call (833) 897-1337. Yes, for prescription drugs: CVS Health. For a list of network retail and mail pharmacies, log on to www.caremark.com or call Customer Service at 1-800-213-0879.	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 services.
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.

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 provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	20% coinsurance	50% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

* 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)	Non-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Pre-certification is required, $300 penalty if services are not pre-certified.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com Note: If a prescription is attempted out of national pharmacy network, it will reject. Please visit www.caremark.com for more details.	Typically Generic (Tier 1)	20% coinsurance (retail and home delivery)	20% coinsurance (retail) and Not covered (home delivery)	Maintenance medications: Required to be filled through CVS90 program or Home Delivery Retail: Limited to a 30-day supply CVS90: Members may only get 90-day Maintenance Medication at CVS/pharmacy, COSTCO Pharmacies, Target, Kroger, and Select independents. Please visit Caremark.com to verify your closest pharmacy for 90-day. These are subject to state laws – based off the state where the pharmacy is located, some of these requirements may be affected. Home Delivery: Limited to a 90-day supply. Specialty: Available in a 30-day supply through CVS Specialty Pharmacy Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.caremark.com. Prescription drug charges apply to the Medical deductible and out-of-pocket limit.
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	20% coinsurance (retail and home delivery)	20% coinsurance (retail) and Not covered (home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	40% coinsurance (retail and home delivery)	40% coinsurance (retail) and Not covered (home delivery)	
	Typically Preferred Specialty (brand and generic) (Tier 4)	For Specialty Drugs, enroll in PrudentRx to get your medication at $0 after your deductible is met. If you do not enroll you are subject to a 30% cost share. If your Specialty Medication is not offered by PrudentRx you will pay the coinsurance with a $250 Max. (retail and home delivery)	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.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Pre-certification is required for outpatient surgery, except for surgery performed in a physician's office; $300 penalty if services are not pre-certified.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Pre-certification is required for outpatient surgery, except for
Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	What You Will Pay Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				surgery performed in a physician's office; $300 penalty if services are not pre-certified.
If you need immediate medical attention	Emergency room care	20% coinsurance	Covered as In-Network	--------none--------
	Emergency medical transportation	20% coinsurance	Covered as In-Network	Pre-certification is required; $300 penalty if services are not pre-certified.
	Urgent care	20% coinsurance	50% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Pre-certification is required; $300 penalty if services are not pre-certified.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Pre-certification is required; $300 penalty if services are not pre-certified.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	0% coinsurance	--------none--------
	Inpatient services	0% coinsurance	0% coinsurance	Pre-certification is required for inpatient mental health/substance abuse treatment (includes residential treatment facility services). Pre-certification is also required for partial hospitalization, and intensive outpatient treatment, and ABA therapy, for mental health and substance abuse treatment; $300 penalty if services are not pre-certified.
If you are	Office visits	20% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	

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

pregnant	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	200 visits/benefit period for Home Health and Private Duty Nursing combined. Pre-certification is required; $300 penalty if services are not pre-certified.
Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	What You Will Pay Non-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Rehabilitation services	20% coinsurance	50% coinsurance	30 visits limit not combined with any other therapy. Limit combined institutional/professional. Limit combined in and out of network. Pre-certification is required for inpatient rehabilitation facility and for outpatient rehabilitation or habilitative services (physical, occupational, and speech therapy) in excess of thirty (30) visits per calendar year. $300 penalty if services are not pre-certified.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	Pre-certification is required, $300 penalty if services are not pre-certified.
	Durable medical equipment	20% coinsurance	50% coinsurance	Pre-certification is required for DME exceeding $1,000; $300 penalty if services are not pre-certified.
	Hospice services	20% coinsurance	50% coinsurance	Pre-certification is required; $300 penalty if services are not pre-certified.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	--------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.)		
• Routine eye care • Cosmetic surgery	• Routine foot care unless you have been diagnosed with diabetes	• Long-term care • Weight loss programs

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

- Glasses for a child
- Dental care
- Eye exam (Child)
- Non-emergency care when traveling outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion	• Acupuncture	• Chiropractic care 30 visits/benefit period
• Hearing aids 1 pair/36 months	• Bariatric surgery	• Gender affirming care
• Private-duty nursing 200 visits/benefit period combined with Home Health	• Infertility treatment $25,000 maximum/lifetime	• Most coverage provided outside the United States. See www.bcbsglobalcore.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: Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division 2, Martin Luther King, Jr. Drive, WestTower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, www.oci.ga.gov/ConsumerService/Home.aspx, 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 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 Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, www.oci.ga.gov/ConsumerService/Home.aspx

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 the 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)

The plan's overall deductible	$1,700
Specialist coinsurance	20%
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:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,960

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

The plan's overall deductible	$1,700
Specialist coinsurance	20%
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:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,520

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

The plan's overall deductible	$1,700
Specialist coinsurance	20%
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:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,000

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 (800) 810-2583

Amharic (**አማርኛ**): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 810-2583 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 (800) 810-2583 .

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՝ (800) 810-2583:

Bassa (Bǎsɔ́ɔ̀ Wùdù): Mì dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nìà kɛ dyí ní, ɔ mɔ̀ nì dyí-bèdɛ̀ìn-dɛ̀ bé m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùùn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dɔ̀ gbo wùdù kɛ, dá (800) 810-2583.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (800) 810-2583 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (800) 810-2583 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(800) 810-2583。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (800) 810-2583.

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 (800) 810-2583.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره تماس بگیرید. (800) 810-2583

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 (800) 810-2583.

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 (800) 810-2583.

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 (800) 810-2583.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્ર◌ો હોય તો, કોઈપણ ખય◌ વગર આપની ભાષામાં મદદ અને મા◌હતી મેળવવાનો તમને અિધકાર છે. દુભા◌ષયા સાથે વાત કરવા માટે, કોલ કરો (800) 810-2583.

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 (800) 810-2583.

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(800) 810-2583 ।

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 (800) 810-2583.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (800) 810-2583.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (800) 810-2583.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (800) 810-2583.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (800) 810-2583

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには (800) 810-2583 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ(800) 810-2583 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (800) 810-2583.

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