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/eoccpasso. 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/sbcglossary or call (855) 333-5730 to request a copy. For your Pharmacy benefits through Express Scripts (Medco) go to www.expressscripts.com or call 1-877-554-3091.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500/person or $1,000/family for In-Network Providers $500/person or $1,000/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 plan, 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
Are there services covered before you meet your deductible?	Yes. Primary Care, Specialist Visit, 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
pocket limit for this plan?	$3,500/person or $7,000/family for In-Network Providers	overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Prescription Drug cost share out-of-network, any member prescription penalties (if applicable), premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information

* For more information about limitations and exceptions, see 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 hospital stay	Facility fee (e.g., hospital roor	20% coinsurance	40% coinsurance	$500 penalty if

* For more information about limitations and exceptions, see 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 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-------

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)

- x Cosmetic surgery
- x Dental Check-up
- x Hearing aids
- x Routine eye care (Adult)
- x Dental care (Adult)
- x Eye exams for a child
- x

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

Other Pharmacy Benefit Inclusions

- x Specialty Drugs
- x Insulin

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

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 kon
një përkthyes, telefononi 1-888-254-2721

Amharic (b ç ù]): Ô ” Ñü R ¯ç W] ˆ é Ü ¥ m Ô ‰% ÷ ‰W g ù - 8g U§ Ñ Wa ô ½% R¢òç Ç Z :ä * : b Ô ‰ :b 5 ù Ì æÔ ç U Â1-888-254-
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1-888-254-2721

Language Access Services:

Language Access Services:

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differen basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Me number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national or disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator, P.O. Box 27401, Mail Drop VA2N02 Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1 1019 (TDD: 1- 80 537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html