




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 1-888-642-4414 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$300 /person or \$600 /family for in-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. Preventive services, office visits, prescription drugs, out-patient surgery, hospital stays, behavioral health, and routine vision and hearing.	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?	Yes. Dental deductible \$50 /person, \$100 /two people, or \$150 /family. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	\$1,500 /person or \$3,000 /family for in-network provider.	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 , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Dental, routine vision and hearing and hearing, premiums , balance-billed 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 .
	Yes. See www.anthem.com or call 1-800-552-2682 for a list of network providers .	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

Important Questions	Answers	Why This Matters:
		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
		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	\$25/visit	Covered as in-network less a 25% reduction in the amount paid by your plan .	Balance billing may occur for out-of-network services.
	Specialist visit	\$40/visit	Covered as in-network less a 25% reduction in the amount paid by your plan .	Balance billing may occur for out-of-network services.
	Preventive care/screening /immunization	No charge	Covered as in-network less a 25% reduction in the amount paid by your plan .	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Balance billing may occur for out-of-network services.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	Covered as in-network less a 25% reduction in the amount paid by your plan .	Balance billing may occur for out-of-network services.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Covered as in-network less a 25% reduction in the amount paid by your plan .	A Health Services Review is required. Balance billing may occur for out-of-network services.

* For more information about limitations and exceptions, see the plan or policy document at www.dhrm.virginia.gov.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at COVA Care Drug List	Tier 1 - Typically Generic drugs	\$15/ copay (retail); \$30/ copay (home delivery)	\$15/ copay (retail); \$30/ copay (home delivery)	Retail up to 34 day supply; home delivery up to 90 day supply. Mandatory generic program. If you or your doctor requests a brand named drug when a generic is available, you pay the brand copay plus the difference between the allowable charge for the generic and the brand named drug.
	Tier 2 - Typically Preferred / Brand drugs	\$30/ copay (retail); \$60/ copay (home delivery)	\$30/ copay (retail); \$60/ copay (home delivery)	
	Tier 3 - Typically Non-Preferred / Specialty drugs	\$45/ copay (retail); \$90/ copay (home delivery)	\$45/ copay (retail); \$90/ copay (home delivery)	
	Tier 4 - Typically Specialty drugs	\$55/ copay (retail); \$110/ copay (home delivery)	\$55/ copay (retail); \$110/ copay (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$125/visit	Covered as in-network less a 25% reduction in the amount paid by your plan .	Balance billing may occur for out-of-network services.
	Physician/surgeon fees	\$25 PCP; \$40 Specialist/visit	Covered as in-network less a 25% reduction in the amount paid by your plan .	Balance billing may occur for out-of-network services.
If you need immediate medical attention	Emergency room care	\$150/visit	Covered as in-network	Copay waived if admitted. Balance billing may occur for out-of-network services.
	Emergency medical transportation	20% coinsurance after deductible	Covered as in-network	Balance billing may occur for out-of-network services.
	Urgent care	\$25 PCP; \$40 Specialist/visit	Covered as in-network less a 25% reduction in the amount paid by your plan .	Balance billing may occur for out-of-network services.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300/stay	Covered as in-network less a 25% reduction in	Balance billing may occur for out-of-network services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			the amount paid by your plan .	
	Physician/surgeon fee	No charge	Covered as in-network less a 25% reduction in the amount paid by your plan .	Balance billing may occur for out-of-network services.
If you need mental health, behavioral health, or substance abuse needs	Outpatient services	Office Visit \$25/visit Other Outpatient \$125/visit	Covered as in-network less a 25% reduction in the amount paid by your plan .	Balance billing may occur for out-of-network services. Employee Assistance Program (EAP) covered at no charge with up to 4 visits per incident per plan year.
	Inpatient services	\$300/stay	Covered as in-network less a 25% reduction in the amount paid by your plan .	
If you are pregnant	Office visits	\$25 PCP; \$40 Specialist/visit	Covered as in-network less a 25% reduction in the amount paid by your plan .	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Balance billing may occur for out-of-network services.
	Childbirth/delivery professional services	No charge	Covered as in-network less a 25% reduction in the amount paid by your plan .	
	Childbirth/delivery facility services	\$300/stay	Covered as in-network less a 25% reduction in the amount paid by your plan .	
If you need help recovering or have other special health needs	Home health care	No charge	Covered as in-network less a 25% reduction in the amount paid by your plan .	90 visits/benefit period. Balance billing may occur for out-of-network services.
	Rehabilitation services	\$35/visit	Covered as in-network less a 25% reduction in the amount paid by your plan .	\$15 copay for physical therapy services only. Balance billing may occur for out-of-network services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	\$35/visit	Covered as in-network less a 25% reduction in the amount paid by your plan .	
	Skilled nursing care	No charge	Covered as in-network less a 25% reduction in the amount paid by your plan .	180 days/benefit period. Balance billing may occur for out-of-network services.
	Durable medical equipment	20% coinsurance after deductible	Covered as in-network less a 25% reduction in the amount paid by your plan .	Balance billing may occur for out-of-network services.
	Hospice service	No charge	Covered as in-network less a 25% reduction in the amount paid by your plan .	Balance billing may occur for out-of-network services.
If your child needs dental or eye care	Eye exam	\$15 copay	\$30 allowance	Balance billing may occur for out-of-network services.
	Glasses	80% of balance after plan pay \$100 allowance for frames. \$20 copay for polycarbonate standard single vision lenses.	\$80 allowance for frames. \$50 allowance for polycarbonate standard single vision lenses.	-----none-----
	Dental check-up	No charge	Covered as in-network	Balance billing may occur for out-of-network services.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Does NOT Cover (This isn't a complete list. Check your policy or plan document for other [excluded services](#).)

- Acupuncture
- Infertility treatment
- Routine foot care unless you have been diagnosed with diabetes
- Cosmetic surgery
- Long-term 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
- Most coverage provided outside the United States. See www.bcbs.com
- Chiropractic care
- Private-duty nursing
- Dental care (adult)
- Hearing aids
- Routine eye care (adult)

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to [appeal](#) or file a [grievance](#). For questions about your rights, this notice, or assistance, you can contact: Director, Department of Human Resource Management, 101 North 14th Street – 12th Floor, Richmond, Virginia 23219-3657. Mark envelope Confidential-Appeal Enclosed. Telephone: 1-888-642-4414.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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	\$300
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$300
■ 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	\$12,840
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$410
Coinsurance	\$209
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$979

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$300
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$300
■ 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	\$7,460
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$1,135
Coinsurance	\$372
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,862

Mia's Simple Fracture

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

■ The plan's overall deductible	\$300
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$300
■ 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	\$1,970
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$300
Copayments	\$835
Coinsurance	\$164
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,299

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-642-4414.

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 1-800-552-2682

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር 1-800-552-2682 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 1-800-552-2682

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՝ 1-800-552-2682 :

Bassa (Bàsɔ̀ Wùdù): M̐ dyi dyi-diè-dɛ̀ bɛ́ bédé b́a céè-dɛ̀ nìà kɛ dyí ní, ɔ̀ m̀ò nì dyí-bédɛ̀n-dɛ̀ bɛ́ m̐ kɛ́ gbo-kpá-kpá kè b̐́ kp̐́ dɛ́ m̐ bídí-wùdùùn b́ó pídyi. B́é m̐ kɛ́ wuɖu-zììn-nyò d̀ò gbo wùdù kɛ́, d́á 1-800-552-2682.

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 1-800-552-2682 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် 1-800-552-2682 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 1-800-552-2682。

Dinka (Dinka): Na n̄ɔŋ thiëc nē ke de yā thorē, ke yin n̄ɔŋ lonɔ̄ bē yi kuony ku w̄ɛr alēu bē ḡɛɛr yic yin ne thonɔ̄ du ke cin wēu tāāuē ke piny. Te k̄or yin ba jam wēnē ran ye thok geryic, ke yin c̄ol 1-800-552-2682.

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 1-800-552-2682.

Farsi (فارسی): 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 1-800-552-2682 تماس بگیرید.

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 1-800-552-2682.

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 1-800-552-2682.

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 1-800-552-2682.

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 1-800-552-2682.

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 1-800-552-2682.

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 1-800-552-2682

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、1-800-552-2682 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ 1-800-552-2682 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura 1-800-552-2682.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 1-800-552-2682 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໄດ້ພົວພັນກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ 1-800-552-2682.

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idíłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjı́ bee níl hodoonih t'áadoo bááh ilínígóó.
Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojı́' hodiłlnih 1-800-552-2682.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् 1-800-552-2682

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyyu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, 1-800-552-2682 bilbilla.

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