




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 (855) 255-9952 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | \$2,000/person or \$4,000/family for In- Network Providers . \$4,000/person or \$8,000/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 policy, the overall family deductible must be met before the plan begins to pay (non-embedded). |
| Are there services covered before you meet your deductible? | Yes. Preventive Care for In- Network Providers . | 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? | \$2,000/person or \$4,000/family for In- Network Providers . \$8,000/person or \$16,000/family for Non- Network Providers . | 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. |
| What is not included in the out-of-pocket limit? | Services deemed not medically necessary by Medical Management and/or Anthem, Non- Network Transplant Services, 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 . |
| Will you pay less if you use a network provider? | Yes, Blue Card PPO. See www.anthem.com or call (855) 255-9952 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 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 | 0% coinsurance | 30% coinsurance | -----none----- |
| | Specialist visit | 0% coinsurance | 30% coinsurance | -----none----- |
| | Preventive care / screening / immunization | No charge | 30% 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. |
| If you have a test | Diagnostic test (x-ray, blood work) | 0% coinsurance | 30% coinsurance | Costs may vary by site of service. |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | 30% coinsurance | Costs may vary by site of service. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com | Tier 1 - Typically Generic | Retail: 0% coinsurance Mail-Order: 0% coinsurance | Not covered | Provider means pharmacy for purposes of this section. Retail: Up to a 30-day supply Mail-Order: Up to a 90-day supply You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a Pre-Notification requirement or may result in a higher cost. If you use a non-network Pharmacy, you are responsible for any amount over the allowed amount. You may be required to use a lower- |
| | Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs | Retail: 0% coinsurance Mail-Order: 0% coinsurance | Not covered | |
| | Tier 3 - Typically Non-Preferred Brand and Generic drugs | Retail: 0% coinsurance Mail-Order: 0% coinsurance | Not covered | |

| | | | | |
|--|--|---|--|---|
| | Tier 4 - Typically Preferred Specialty (brand and generic) | Retail: 0% coinsurance Mail-Order: Not covered | Not covered | cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Tier 1 Contraceptives covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance | 30% coinsurance | -----none----- |
| | Physician/surgeon fees | 0% coinsurance | 30% coinsurance | -----none----- |
| If you need immediate medical attention | Emergency room care | 0% coinsurance | Covered as In- Network | -----none----- |
| | Emergency medical transportation | 0% coinsurance | Covered as In- Network | Non-emergency non- network Ambulance Services are limited to \$50,000 per trip. |

* 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) | |
| | Urgent care | 0% coinsurance | 30% coinsurance | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 0% coinsurance | 30% coinsurance | 60 days/benefit period for Inpatient rehabilitation. |
| | Physician/surgeon fees | 0% coinsurance | 30% coinsurance | -----none----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit 0% coinsurance | Office Visit 30% coinsurance | Office Visit -----none----- |
| | | Other Outpatient 0% coinsurance | Other Outpatient 30% coinsurance | Other Outpatient -----none----- |
| | Inpatient services | 0% coinsurance | 30% coinsurance | -----none----- |
| If you are pregnant | Office visits | 0% coinsurance | 30% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 0% coinsurance | 30% coinsurance | |
| | Childbirth/delivery facility services | 0% coinsurance | 30% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 0% coinsurance | 30% coinsurance | 30 visits/benefit period for Non- Network Providers . |
| | Rehabilitation services | 0% coinsurance | 30% coinsurance | Costs may vary by site of service. *See Therapy Services section. |
| | Habilitation services | 0% coinsurance | 30% coinsurance | |
| | Skilled nursing care | 0% coinsurance | 30% coinsurance | 180 days/benefit period for skilled nursing services. |
| | Durable medical equipment | 0% coinsurance | 30% coinsurance | *See Durable Medical Equipment Section |
| | Hospice services | 0% coinsurance | 30% coinsurance | -----none----- |
| If your child needs dental or eye care | Children's eye exam | 0% coinsurance | 30% coinsurance | *See Vision Services section |
| | 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](#).)

- | | | |
|-----------------------|---------------------------|--------------------|
| • Acupuncture | • Bariatric surgery | • Cosmetic surgery |
| • Dental care (Adult) | • Dental care (Pediatric) | • Dental Check-up |
| • Glasses for a child | • Infertility treatment | • Long-term care |
| • Routine foot care | • Weight loss programs | |

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

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

- Chiropractic care 12 visits/benefit period
- Private-duty nursing in a Home Setting only
- Hearing aids 1 item/ear every 3 years
- Routine eye care (Adult)
- 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: Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (800) 686-1526, (614) 644-2673, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, 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: 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 105568, Atlanta GA 30348-5568

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

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 | \$2,000 |
| ■ Specialist coinsurance | 0% |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 0% |

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*)

Managing Joe's Type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$2,000 |
| ■ Specialist coinsurance | 0% |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 0% |

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*)

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$2,000 |
| ■ Specialist coinsurance | 0% |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 0% |

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 | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
|-----------------------------------|----------------|-----------------------------------|----------------|-----------------------------------|----------------|
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| Cost Sharing | | Cost Sharing | | Cost Sharing | |
| Deductibles | \$2,000 | Deductibles | \$2,000 | Deductibles | \$2,000 |
| Copayments | \$0 | Copayments | \$0 | Copayments | \$0 |
| Coinsurance | \$0 | Coinsurance | \$0 | Coinsurance | \$0 |
| <i>What isn't covered</i> | | <i>What isn't covered</i> | | <i>What isn't covered</i> | |
| Limits or exclusions | \$60 | Limits or exclusions | \$20 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$2,060 | The total Joe would pay is | \$2,020 | 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 (855) 255-9952

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 255-9952 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 (855) 255-9952.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչ ի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (855) 255-9952:

ḅó pídyi. Bé m̄ ké wuḍu-zìin-nyò d̄ò gbo wùḍù kε, ḍá (855) 255-9952.

একজন দোভাষীর সাথে কথা বলার জন্য (855) 255-9952

သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 255-9952 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) 255-9952。

ba jam wēnē ran ye thok geryic, ke yin cōl (855) 255-9952.

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) 255-9952.

هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 255-9952 تماس بگیرید.

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) 255-9952.

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) 255-9952.

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) 255-9952.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દલાહયા સાથે વાત કરવા માટે, કોલ કરો (855) 255-9952.

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) 255-9952.

दुभाषिये से बात करने के लिए, कॉल करें(855) 255-9952

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) 255-9952.

Igbo (Igbo): O bụr u na i nwere ajuju o bula gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o bula. Ka gi na okowa okwu kwuo okwu, kpoo (855) 255-9952.

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 (855) 255-9952.

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 (855) 255-9952.

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 (855) 255-9952

す。通訳と話すには (855) 255-9952 にお電話ください。

Language Access Services:

(855) 255-9952

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuze, akura (855) 255-9952.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 255-9952 로 문의하십시오.

ເພື່ອໂອ້ນລັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (855) 255-9952.

Ata' halne'igúú la' bich'i' hadeesdizih ninizingo koj' hodiilnih (855) 255-9952.

दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (855) 255-9952

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 255-9952 bilbilla.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (855) 255-9952 aa.

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (855) 255-9952.

Portuguese (Português): Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (855) 255-9952.

(855) 255-9952

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Language Access Services:

gratuit. Pentru a vă adresa unui interpret, contactați telefonic (855) 255-9952.

информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 255-9952.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i leni tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totoqi. Ina ia talanoa i se tagata faaliliu, vili (855) 255-9952.

Serbian (Srpski): Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (855) 255-9952.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 255-9952.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 255-9952.

Thai (ไทย): หากท่านมีคำถามเกี่ยวกับเอกสารฉบับนี้ จะได้รับความช่วยเหลือและขอข้อมูลในภาษาของท่านโดยไม่มค
หากท่านมีคำถามเกี่ยวกับเอกสารฉบับนี้ จะได้รับความช่วยเหลือและขอข้อมูลในภาษาของท่านโดยไม่มค

(855) 255-9952 เพื่อดูข้อมูลเพิ่มเติม

інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (855) 255-9952.

لئے، (855) 255-9952 پر کال کریں۔

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 255-9952.

. (855) 255-9952

Yoruba (Yorùbá): Tí o bá ní èyíkẹyí ibèrè nípa àkòsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lẹ́fẹ́. Bá wa ògbùfọ̀ kan sọrọ̀, pe (855) 255-9952.

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 differently on the 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 isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services 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 origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, 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 1-800-368-1019 (TDD: 1- 800-537-7697) 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>