



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 how 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/fi>. 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 (866) 837-4596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$2,500/single or \$4,000/family for In- Network Providers . \$4,000/single or \$7,500/family for Out-of- 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 , 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 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 with 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 ?	\$2,500/single or \$4,000/family for In- Network Providers . \$7,000/single or \$13,500/family for Out-of- Network Providers .	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit ?	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 .
Will you pay less if you use a network provider ?	Yes. PPO. See www.anthem.com or call (866) 837-4596 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)	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	0% coinsurance	30% coinsurance	-----none-----
	Specialist visit	0% coinsurance	30% coinsurance	-----none-----
	Preventive care / Screening / Immunization	No charge	30% coinsurance	There may be other levels of cost share that are contingent on how services are provided. 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)	Lab - Office 0% coinsurance X-Ray - Office 0% coinsurance	Lab - Office 30% coinsurance X-Ray - Office 30% coinsurance	Lab - Office -----none----- X-Ray - Office -----none-----
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Tier 1 - Typically Generic	0% coinsurance (retail and home delivery)	Not covered	Precertification may be required for certain Prescription Drugs. Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. *See Prescription Drug section of your evidence of coverage, available in the footnote below.
	Tier 2 - Typically Preferred/Brand	0% coinsurance (retail and home delivery)	Not covered	
	Tier 3 - Typically Non-Preferred/ Specialty Drugs	0% coinsurance (retail and home delivery)	Not 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	-----none-----
	Urgent care	0% coinsurance	Covered as In- Network	-----none-----

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	30 day limit/calendar year 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	100 visits/year combined
	Rehabilitation services	0% coinsurance	30% coinsurance	Coverage is limited to 20 visits each per year for Physical, Occupational and Speech Therapy. Costs may vary by site of service.
	Habilitation services	0% coinsurance	30% coinsurance	Habilitation visits count towards your rehabilitation limit.
	Skilled nursing care	0% coinsurance	30% coinsurance	100 days/year combined
	Durable medical equipment	0% coinsurance	30% coinsurance	-----none-----
	Hospice services	0% coinsurance	30% coinsurance	-----none-----
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	*See Vision Services section
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	*See Dental Services section

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

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**.)

<ul style="list-style-type: none">• Acupuncture• Dental care (adult)• Glasses for a child• Non-emergency care when traveling outside the U.S. • Routine eye care (adult)	<ul style="list-style-type: none">• Bariatric surgery• Dental Check-up• Infertility treatment• Preauthorization - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. To find out which services require Preauthorization and to be sure that Preauthorization has been given, you may contact us.• Routine foot care unless you have been diagnosed with diabetes.	<ul style="list-style-type: none">• Cosmetic surgery• Eye exams for a child• Long term care• Private duty nursing • Weight loss programs
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your **plan document.)**

<ul style="list-style-type: none">• Abortion	<ul style="list-style-type: none">• Hearing aids (limits apply)	<ul style="list-style-type: none">• Spinal Manipulation/Chiropractic (limits apply)
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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 Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 denial of a **claim**. This complaint is call 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, 700 Broadway, Mail Stop CO0104-0430, Denver, CO 80273

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490

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 prenatal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) **\$2,500**
- [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*)

Total Example Cost	\$12,731
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,560

Managing Joe's Type 2 Diabetes

(a year of routine In-Network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) **\$2,500**
- [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*)

Total Example Cost	\$7,389
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,555

Mia's Simple Fracture

(In-Network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) **\$2,500**
- [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	\$1,925
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,925
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,925

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services

(TTY/TDD: 711)

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 <https://www.hhs.gov/ocr/office/file/index.html>.

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Appendix A
Colorado Supplement to the Summary of Benefits and Coverage Form

TYPE OF COVERAGE

Insurance Company Name	Anthem Blue Cross and Blue Shield
Name of Plan	Health Savings Account (HSA-Compatible) PPO Plan 22
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Preferred Provider Organization (PPO)*
3. Areas of Colorado where plan is available	Plan is available throughout Colorado.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Notice: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	<p>SINGLE – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid.</p> <p>FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid for any family member. The family deductible can be met by one or more individuals.</p>
5. Out-of-Pocket Maximum	<p>SINGLE – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid at 100%.</p> <p>FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid at 100% for any family member. The family out-of-pocket can be met by one or more individuals.</p>

*Network access plans are available on request at the Member Services number on your member ID card or can be obtained by going to www.anthem.com/co/networkaccess.

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6. What is included in the In-Network Out-of-Pocket Maximum?	Most In-Network Copayments and Coinsurance. Not included in the Out-of-Pocket Maximum for this plan are Pre-Authorization Penalties, Services in excess of the allowed benefit (benefit cap), Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.
7. Is pediatric dental covered by this plan?	No, the plan does not include pediatric dental.
8. What cancer screening are covered?	The following screenings are covered under your benefits subject to the terms and conditions of your certificate of coverage: Colorectal Cancer Screening, Mammogram Screenings, Pap Test, and Prostate Cancer Screenings.

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
9. If the provider charges more for a covered service that the plan normally pays, does the enrollee have to pay the difference?	No.	Yes, you will be responsible for paying the difference between the Maximum Allowed Amount and the non-participating Provider's Billed Charges (sometimes called "Balance Billing"). The amounts you pay for Out-of-Network Covered Services are in addition to your balance billing costs.
10. Does the plan have a binding arbitration clause?	Yes.	

Questions: Call (866) 837-4596 or visit us at www.anthem.com.

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance

Consumer Affairs Section

1560 Broadway, Suite 850

Denver, CO 80202

Call 303-894-7490 (in-state toll-free 800-830-3745)

Email: insurance@dora.state.co.us

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 (866) 837-4596.