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 (877) 811-3106 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**/single or **$0**/family for In-Network Providers. **Not Covered** 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, 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. Prescription Drugs, Preventive care, Primary Care visit, and Specialist visit 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?	**$1,000**/single or **$2,000**/family for In-Network Providers. **Not Covered** 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?	Preauthorization Penalties, 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 HMO. See www.anthem.com or call (855) 333-5735 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	$25/visit	Not covered	--------none--------
	Specialist visit	$25/visit	Not covered	--------none--------
	Preventive care/Screening/ Immunization	No charge	Not covered	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 No charge X-Ray - Office No charge	Lab - Office Not covered X-Ray - Office Not covered	Lab - Office --------none-------- X-Ray - Office --------none--------
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	--------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	$8/prescription (retail) or $16/prescription (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	$25/prescription (retail) or $50/prescription (home delivery)	Not covered	
	Tier 3 - Typically Non-Preferred /Specialty Drugs	$45/prescription (retail) or $90/prescription (home delivery)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	--------none--------
	Physician/surgeon fees	No charge	Not covered	--------none--------
If you need immediate medical attention	Emergency Room care	$100/visit	Covered as In-Network	Copayment waived if admitted
	Emergency Medical Transportation	No charge	Covered as In-Network	--------none--------
	Urgent care	$50/visit	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)	$250/admission	Not covered	30 day limit/calendar year for Inpatient Rehabilitation
	Physician/surgeon fees	No charge	Not covered	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $25/visit Other Outpatient No charge	Office Visit Not covered Other Outpatient Not covered	Office Visit --------none-------- Other Outpatient --------none--------
	Inpatient services	$250/admission	Not covered	--------none--------
If you are pregnant	Office visits	$25/visit	Not covered	Only one copayment applies for office visits and childbirth/delivery professional services per pregnancy. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	$25/visit	Not covered	
	Childbirth/delivery facility services	$250/admission	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	100 visits/year
	Rehabilitation services	$25/visit	Not covered	Coverage is limited to 20 visits each per year for Physical, Occupational and Speech Therapy. Costs may vary by site of service.
	Habilitation services	$25/visit	Not covered	Habilitation visits count towards your rehabilitation limit.
	Skilled nursing care	No charge	Not covered	100 days/year
	Durable medical equipment	No charge	Not covered	--------none--------
	Hospice services	No charge	Not covered	--------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.)		
• Acupuncture • Dental care (adult) • Glasses for a child • Non-emergency care when traveling outside the U.S. • Routine eye care (adult)	• 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.	• Cosmetic surgery • Eye exams for a child • Long term care • Private duty nursing • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion	• Hearing aids (limits apply)	• Spinal Manipulation/Chiropractic (limits apply)

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	$0
Specialist copayment	$25
Hospital (facility) copayment	$250
Other coinsurance	None

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:	
Cost Sharing	
Deductibles	$0
Copayments	$258
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$318**

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

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	$250
Other coinsurance	None

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:	
Cost Sharing	
Deductibles	$0
Copayments	$508
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$563**

Mia's Simple Fracture
(In-Network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$25
Hospital (facility) coinsurance	$250
Other coinsurance	None

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:	
Cost Sharing	
Deductibles	$0
Copayments	$275
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$275**

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/protal/lobby.jsf. Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

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Anthem BlueCross BlueShield

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	BlueAdvantage 4 20-0/2000 15/50/70/30% ESS
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Health maintenance organization (HMO)*
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	SINGLE – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met. FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by [2] or more individuals.
5. Out-of-Pocket Maximum	SINGLE – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met. FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by [2] or more individuals.

*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.

6. What is included in the In-Network Out-of-Pocket Maximum?	Most In-Network Copays and Coinsurance. Not included in the Out-of-Pocket Maximum for this plan are Pre-Authorization Penalties, Services in excess of 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 screenings are covered?	The following screenings are covered under your benefits subject to the terms and conditions of your certificate of coverage: Routine colorectal cancer screenings and colonoscopies, Mammogram Screenings, Pap tests and Prostate Cancer Screenings.

USING THE PLAN

	IN-NETWORK	**OUT-OF-NETWORK**
9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No.	Yes, out-of-network care is not covered except as noted.
10. Does the plan have a binding arbitration clause?	Yes.	

Questions: Call **(877) 811-3106** or visit us at http://www.anthem.com
If you are not satisfied with the resolution of your complaint or grievance, contact:
Colorado Division of Insurance:
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-State, toll-free: 800-930-3745)
Email:dora_insurance@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 (877) 811-3106.