**Summary of Benefits and Coverage:** What this **Plan** Covers & What You Pay For Covered Services **Coverage Period: -**

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| **Anthem® HealthKeepersAnthem® BlueCross and BlueShieldAnthem® BlueCross and BlueShield and its affiliate HealthKeepers, Inc.Empire BlueCross BlueShieldEmpire BlueCrossAnthem® BlueCrossAnthem® Blue Cross Life and Health Insurance CompanyBlueCross and BlueShield of GeorgiaBlueCross and BlueShield Healthcare Plan of GeorgiaAnthem® BlueCross and BlueShield** | **Coverage for:** Individual + Family | **Plan Type: + + +** | |
|  | | **HSAHRA HIA Plus** |

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| image2 | **The Summary of Benefits and Coverage (SBC) document will help you choose a health** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)**. The SBC shows you how you and the** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **would share the cost for covered health care services. NOTE: Information about the cost of this** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **(called the** [[**premium**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)**) 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.empireblue.com/eocdps/ SMG01012018https://eoc.anthem.com/eocdps/ SMG01012018https://eoc.anthem.com/eocdps/ IND01012018https://eoc.empireblue.com/eocdps/ IND01012018<https://eoc.anthem.com/eocdps/aso>https://eoc.anthem.com/eocdps/fihttps://eoc.empireblue.com/eocdps/fi. For general definitions of common terms, such as [[allowed amount](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[balance billing](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[coinsurance](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[copayment](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[deductible](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[provider](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), or other underlined terms see the Glossary. You can view the Glossary at [[www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/)](http://www.healthcare.gov/sbc-glossary/) or call to request a copy. | |

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| **Important Questions** | **Answers** | **Why This Matters:** |
| **What is the overall deductible?** | /person or /family for In-Network Providers. /person or /family for Non-Network Providers./person or /family for In-Network Providers./person or /family./person or /family for Level 1 NetworkValue Tier 1 In-Network (INET)Tier 1 NetworkPreferred Network Providers and Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 NetworkIn-Network Providers combined. /person or /family for Out-of-NetworkNon-Network Providers./person or /family for Level 1 NetworkValue Tier 1 In-Network (INET)Tier 1 NetworkPreferred Network Providers and Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 NetworkIn-Network Providers combined./person or /family for Level 1 NetworkValue Tier 1 In-Network (INET)Tier 1 NetworkPreferred Network Providers. /person or /family for Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 NetworkIn-Network Providers. /person or /family for Out-of-NetworkNon-Network Providers./person or /family for Level 1 NetworkValue Tier 1 In-Network (INET)Tier 1 NetworkPreferred Network Providers. /person or /family for Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 NetworkIn-Network Providers./person or /family. An HRA is available to reimburse you for certain deductible and coinsurance amounts. | 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. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Primary Care Specialist Visit Preventive Care for Preferred, [In-Network] and [Non-Network] Providers.  Primary Care Specialist Visit Preventive Care for Preferred and [In-Network] Providers.  Tier 1a Tier 1b Tier 1 Tier 2 Tier 3 Tier 4 Tier 5 Prescription Drugs for Preferred, [In-Network] and [Non-Network] Providers.  Tier 1a Tier 1b Tier 1 Tier 2 Tier 3 Tier 4 Tier 5 Prescription Drugs for Preferred and [In-Network] Providers.  Dental Vision for In-Network and Non-Network Providers  Dental Vision 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/>](https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| **Are there other deductibles for specific services?** | Yes.No. /person or /family for Prescription Drugs. /person for Prescription Drugs. /person or /family for Prescription Drugs Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 NetworkIn-Network Providers. /person or /family for Prescription Drugs Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 Network In-Network Providers. /person or /family for Prescription Drugs for Level 1 NetworkValue Tier 1 In-Network (INET)Tier 1 NetworkPreferred Network and Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 Network In-Network Providers combined. /person or /family for Prescription Drugs for Level 1 NetworkValue Tier 1 In-Network (INET)Tier 1 NetworkPreferred Network and Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 Network In-Network Providers combined. /person for Dental. /person for Dental Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 Network In-Network Providers.$50/family for Home Health care Level 1 NetworkValue Tier 1 In-Network (INET)Tier 1 NetworkPreferred Network and Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 Network In-Network Providers combined.$50/family for Home Health care Level 1 NetworkValue Tier 1 In-Network (INET)Tier 1 NetworkPreferred Network, Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 Network In-Network and Out-of-Network (OON)Non-Network Providers combined.$50/family for Home Health care Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 Network In-Network Providers.$50/family for Home Health care Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 Network In-Network and Out-of-Network (OON)Non-Network Providers combined. | 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.You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | /person or /family for In-Network Providers. /person or /family for Non-Network Providers./person or /family for In-Network Providers./person or /family.Not Applicable./person or /family for Level 1 NetworkValue Tier 1 In-Network (INET)Tier 1 NetworkPreferred Network Providers and Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 NetworkIn-Network Providers combined. /person or /family for Out-of-NetworkNon-Network Providers./person or /family for Level 1 NetworkValue Tier 1 In-Network (INET)Tier 1 NetworkPreferred Network Providers and Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 NetworkIn-Network Providers combined./person or /family.Not Applicable. | 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. If you have other family members in this plan, the overall family out-of-pocket limit must be met. This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, health care this plan doesn't cover.Premiums, balance-billing charges, health care this plan doesn't cover, and Non-Network Transplants.Not Applicable. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | Yes, . See www.anthem.comwww.anthem.com/ca[www.bcbsga.com](http://www.bcbsga.com)<http://www.empireblue.com> or call for a list of network providers.Not Applicable. | You pay the least if you use a provider in Level 1 NetworkValue Tier 1 In-Network (INET)Tier 1 NetworkPreferred Network. You pay more if you use a provider in Level 2 NetworkParticipating Tier 2 In-Network (INET)Tier 2 NetworkIn-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). 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-networkprovider for some services (such as lab work). Check with your provider before you get services.This plan does not use a provider network. You can receive covered services from any provider. |
| **Do you need a referral to see a specialist?** | Yes.No. | You can see the specialist you choose without a referral.This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

| image3 | All [[**copayment**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) and [[**coinsurance**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) costs shown in this chart are after your [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) has been met, if a [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) applies. |
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| **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)** | | |  |
| **Common**  **Medical Event** | **Services You May Need** | **What You Will Pay** | | | | | | **Limitations, Exceptions, & Other Important Information** |
|  |  | **Level 1 Network ProviderValue Tier 1 In-Network (INET) ProviderTier 1 Network ProviderPreferred Network Provider**  **(You will pay the least)** | **Level 2 Network ProviderParticipating Tier 2 In-Network (INET) ProviderTier 2 Network ProviderIn-Network Provider**  **(You will pay more)** | | | | **Out-of-Network (OON) ProviderNon-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 | PCP    EPHC | | | |  | | --------none--------All office visit copayments count towards the same visit limit.Hospital clinics are not covered. |
|  | Specialist visit | Specialist    Specialist Tier 2 | | | |  | | --------none--------All office visit copayments count towards the same visit limit. |
|  | Preventive care/screening/  immunization |  | | | |  | | Prescribed FDA approved contraceptives are not subject to cost-shares.Immunizations for children prior to their 6th birthday have no cost share for In-Network and Non-Network charges.Non-Network preventive care services for children prior to their 6th birthday have no deductible.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 visit a health care provider’s office or clinic** | Primary care visit to treat an injury or illness | Not Applicable | | PCP    EPHC | | |  | --------none--------All office visit copayments count towards the same visit limit.Hospital clinics are not covered. |
|  | Specialist visit | Not Applicable | | Specialist    Specialist Tier 2  Specialist  Specialist    Specialist Tier 2 | | |  | --------none--------All office visit copayments count towards the same visit limit. |
|  | Preventive care/ screening/  immunization | Not Applicable | |  | | |  | Prescribed FDA approved contraceptives are not subject to cost-shares.Immunizations for children prior to their 6th birthday have no cost share for In-Network and Non-Network charges.Non-Network preventive care services for children prior to their 6th birthday have no deductible.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    X-Ray – Office | | | | Lab – Office    X-Ray – Office | | --------none-------- All office visit copayments count towards the same visit limit.Costs may vary by site of service.Costs may vary by site of serviceIncludes coverage for Breast Tomosynthesis |
|  | Imaging (CT/PET scans, MRIs) |  | | | |  | | --------none--------All office visit copayments count towards the same visit limit.Costs may vary by site of service.Costs may vary by site of service. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab – Office  Not Applicable X-Ray – Office  Not Applicable Not Applicable | | Lab – Office   X-Ray – Office | | | Lab – Office   X-Ray – Office | --------none--------All office visit copayments count towards the same visit limit.Costs may vary by site of service.Costs may vary by site of serviceIncludes coverage for Breast Tomosynthesis |
|  | Imaging (CT/PET scans, MRIs) | Not Applicable | |  | | |  | --------none--------All office visit copayments count towards the same visit limit.Costs may vary by site of service.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 <https://www11.empireblue.com/pharmacyinformation/><http://www.anthem.com/pharmacyinformation/>  Select Drug ListNational Drug ListEssential Drug List Traditional Open Drug List | Tier 1 - Typically GenericTier 1a - Typically Lower Cost Generic | (retail) and (home delivery) (retail) and (home delivery) | | | | (retail) and (home delivery) (retail) and (home delivery) | | Most home delivery is 90-day supply.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. \*See Prescription Drug section of the plan or policy document (e.g. evidence of coverage or certificate). \*See Prescription Drug section. |
|  | Tier 1b - Typically Generic | (retail) and (home delivery) | | | | (retail) and (home delivery) | |  |
|  | Tier 2 - Typically Preferred Brand & Non-Preferred Generic DrugsTier 2 - Typically Preferred Brand | (retail) and (home delivery) | | | | (retail) and (home delivery) | |  |
|  | Tier 3 - Typically Non-Preferred Brand and Generic drugs | (retail) and (home delivery) | | | | (retail) and (home delivery) | |  |
|  | Tier 4 - Typically Preferred Specialty (brand and generic) | (retail) and (home delivery) | | | | (retail) and (home delivery) | |  |
|  | Tier 5 - Typically Non-Preferred Specialty (brand and generic) | (retail) and (home delivery) | | | | (retail) and (home delivery) | |  |
| **If you need drugs to treat your illness or condition**  More information about **prescription drug coverage** is available at <https://www11.empireblue.com/pharmacyinformation/><http://www.anthem.com/pharmacyinformation/>    Select Drug ListNational Drug ListEssential Drug List Traditional Open Drug List | Tier 1 - Typically GenericTier 1a - Typically Lower Cost Generic | (retail) and (home delivery) (retail) and (home delivery)Not Applicable | | (retail)  (retail)  (retail)  (retail) | | | (retail) and (home delivery) (retail) and (home delivery) | Most home delivery is 90-day supply.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. \*See Prescription Drug section of the plan or policy document (e.g. evidence of coverage or certificate). \*See Prescription Drug section. |
|  | Tier 1b - Typically Generic | (retail) and  (home delivery)Not Applicable | | (retail)  (retail) | | | (retail) and (home delivery) |  |
|  | Tier 2 - Typically Preferred Brand & Non-Preferred Generic DrugsTier 2 - Typically Preferred Brand | (retail) and (home delivery)Not Applicable | | (retail)  (retail) | | | (retail) and (home delivery) |  |
|  | Tier 3 - Typically Non-Preferred Brand and Generic drugs | (retail) and (home delivery)Not Applicable | | (retail)  (retail) | | | (retail) and (home delivery) |  |
|  | Tier 4 - Typically Preferred Specialty (brand and generic) | (retail) and (home delivery)Not Applicable | | (retail)  (retail) | | | (retail) and (home delivery) |  |
|  | Tier 5 - Typically Non-Preferred Specialty (brand and generic) | (retail) and (home delivery)Not Applicable | | (retail)  (retail) | | | (retail) and (home delivery) |  |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) |  | | | |  | | --------none--------Costs may vary by site of service. |
|  | Physician/surgeon fees |  | | | |  | | --------none-------- for Outpatient Anesthesia. for Outpatient Anesthesia In-Network Providers. for Outpatient Anesthesia Non-Network Providers.Costs may vary by site of service. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not Applicable | |  | | |  | --------none--------Costs may vary by site of service. |
|  | Physician/surgeon fees | Not Applicable | |  | | |  | --------none-------- for Outpatient Anesthesia. for Outpatient Anesthesia Level 1 Network ProvidersValue Tier 1 In-Network (INET) ProvidersTier 1 Network ProvidersPreferred Network Providers and Level 2 Network ProvidersParticipating Tier 2 In-Network (INET) ProvidersTier 2 Network ProvidersIn-Network Providers. for Outpatient Anesthesia Out-of-Network ProvidersNon-Network Providers. for Outpatient Anesthesia Level 1 Network ProvidersValue Tier 1 In-Network (INET) ProvidersTier 1 Network ProvidersPreferred Network Providers and Out-of-Network ProvidersNon-Network Providers. for Outpatient Anesthesia Level 2 Network ProvidersParticipating Tier 2 In-Network (INET) ProvidersTier 2 Network ProvidersIn-Network Providers. for Outpatient Anesthesia Level 1 Network ProvidersValue Tier 1 In-Network (INET) ProvidersTier 1 Network ProvidersPreferred Network Providers. for Outpatient Anesthesia Level 2 Network ProvidersParticipating Tier 2 In-Network (INET) ProvidersTier 2 Network ProvidersIn-Network Providers and Out-of-Network ProvidersNon-Network Providers.Costs may vary by site of service. |
| **If you need immediate medical attention** | Emergency room care |  | | | |  | | --------none--------Copay waived if admitted.Cost share except deductible waived if admitted. |
|  | Emergency medical transportation |  | | | |  | | --------none-------- |
|  | Urgent care |  | | | |  | | --------none--------Urgent Care from Non-Participating Urgent Care Centers or Physicians in Our Service Area without a preauthorization is not covered.If additional services are provided, these services may be subject to deductible and coinsurance. |
| **If you need immediate medical attention** | Emergency room care | Not Applicable | |  | | |  | --------none--------Copay waived if admitted.Cost share except deductible waived if. |
|  | Emergency medical transportation | Not Applicable | |  | | |  | --------none-------- |
|  | Urgent care | Not Applicable | |  | | |  | --------none--------Urgent Care from Non-Participating Urgent Care Centers or Physicians in Our Service Area without a preauthorization is not covered.If additional services are provided, these services may be subject to deductible and coinsurance. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) |  | | | |  | | --------none-------- / for Inpatient rehabilitation. / for Inpatient rehabilitation In-Network Providers. / for Inpatient rehabilitation and skilled nursing services combined. / for Inpatient rehabilitation and skilled nursing services combined In- Network Providers. / for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined. / for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined In- Network Providers. / for Inpatient physical medicine, rehabilitation including day rehabilitation programs. / for Inpatient physical medicine, rehabilitation including day rehabilitation programs In- Network Providers. |
|  | Physician/surgeon fees |  | | | |  | | --------none-------- for Inpatient Anesthesia. for Inpatient Anesthesia In-Network Providers. for Inpatient Anesthesia Non-Network Providers.Costs may vary by site of service. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not Applicable | |  | | |  | -----none----- / for Inpatient rehabilitation. / for Inpatient rehabilitation Level 1 Network ProvidersValue Tier 1 In-Network (INET) ProviderTier 1 Network ProvidersPreferred Network Providers and Level 2 Network ProvidersParticipating Tier 2 In-Network (INET) ProvidersTier 2 Network ProvidersIn-Network Providers combined. / for Inpatient rehabilitation and skilled nursing services combined. / for Inpatient rehabilitation and skilled nursing services combined Level 1 Network ProvidersValue Tier 1 In-Network (INET) ProviderTier 1 Network ProvidersPreferred Network Providers and Level 2 Network ProvidersParticipating Tier 2 In-Network (INET) ProvidersTier 2 Network ProvidersIn-Network Providers combined. / for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined. / for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined Level 1 Network ProvidersValue Tier 1 In-Network (INET) ProviderTier 1 Network ProvidersPreferred Network Providers and Level 2 Network ProvidersParticipating Tier 2 In-Network (INET) ProvidersTier 2 Network ProvidersIn-Network Providers combined. / for Inpatient physical medicine, rehabilitation including day rehabilitation programs. / for Inpatient physical medicine, rehabilitation including day rehabilitation programs Level 1 Network ProvidersValue Tier 1 In-Network (INET) ProviderTier 1 Network ProvidersPreferred Network Providers and Level 2 Network ProvidersParticipating Tier 2 In-Network (INET) ProvidersTier 2 Network ProvidersIn-Network Providers combined. |
|  | Physician/surgeon fees | Not Applicable | |  | | |  | --------none-------- for Inpatient Anesthesia. for Inpatient Anesthesia Level 1 Network ProvidersValue Tier 1 In-Network (INET) ProvidersTier 1 Network ProvidersPreferred Network Providers and Level 2 Network ProvidersParticipating Tier 2 In-Network (INET) ProvidersTier 2 Network ProvidersIn-Network Providers. for Inpatient Anesthesia Out-of-Network ProvidersNon-Network Providers. for Inpatient Anesthesia Level 1 Network ProvidersValue Tier 1 In-Network (INET) ProvidersTier 1 Network ProvidersPreferred Network Providers and Out-of-Network ProvidersNon-Network Providers. for Inpatient Anesthesia Level 2 Network ProvidersParticipating Tier 2 In-Network (INET) ProvidersTier 2 Network ProvidersIn-Network Providers for Inpatient Anesthesia Level 1 Network ProvidersValue Tier 1 In-Network (INET) ProvidersTier 1 Network ProvidersPreferred Network Providers. for Inpatient Anesthesia Level 2 Network ProvidersParticipating Tier 2 In-Network (INET) ProvidersTier 2 Network ProvidersIn-Network Providers and Out-of-Network ProvidersNon-Network Providers. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit    Other Outpatient | | | | Office Visit    Other Outpatient | | Office Visit  --------none--------  Includes 2 non-network office visits.  Other Outpatient  --------none-------- |
|  | Inpatient services |  | | | |  | | --------none-------- |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit    Other Outpatient    Not Applicable | | Office Visit    Other Outpatient | | | Office Visit    Other Outpatient | Office Visit  --------none--------  Includes 2 non-network office visits.  Other Outpatient  --------none-------- |
|  | Inpatient services | Not Applicable | |  | | |  | --------none-------- |
| **If you are pregnant** | Office visits |  | | | |  | | Cost sharing does not apply for preventive services.One copayment per pregnancy for both office visits and childbirth/delivery professional services.In-Network preventive services, routine prenatal office visits and other preventive prenatal care and screenings are covered at 100%.In-Network preventative prenatal and postnatal services are covered at 100%. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).Postpartum office visits are part of the professional maternity services. |
|  | Childbirth/delivery professional services |  | | | |  | |  |
|  | Childbirth/delivery facility services |  | | | |  | |  |
| **If you are pregnant** | Office visits | Not Applicable | |  | | |  | Cost sharing does not apply for preventive services.One copayment per pregnancy for both office visits and childbirth/delivery professional services.In-Network preventive services, routine prenatal office visits and other preventive prenatal care and screenings are covered at 100%.In-Network preventative prenatal and postnatal services are covered at 100%. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).Postpartum office visits are part of the professional maternity services. |
|  | Childbirth/delivery professional services | Not Applicable | |  | | |  |  |
|  | Childbirth/delivery facility services | Not Applicable | |  | | |  |  |
| **If you need help recovering or have other special health needs** | Home health care |  | | | |  | | / . / In-Network Provider. / for Home Health and Private Duty Nursing combined. / for Home Health and Private Duty Nursing combined In-Network Providers. |
|  | Rehabilitation services |  | | | |  | | \*See Therapy Services section |
|  | Habilitation services |  | | | |  | |  |
|  | Skilled nursing care |  | | | |  | | / for Inpatient rehabilitation and skilled nursing services combined. / for Inpatient rehabilitation and skilled nursing services combined for In-Network Providers. / for Inpatient rehabilitation and skilled nursing services combined for Non-Network Providers. / for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined. / for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined for In-Network Providers. / for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined for Non-Network Providers. |
|  | Durable medical equipment |  | | | |  | | \*See Durable Medical Equipment Section |
|  | Hospice services |  | | | |  | | --------none-------- / . / In-Network Providers. |
| **If you need help recovering or have other special health needs** | Home health care | Not Applicable | |  | | |  | / / Level 1 Network ProviderValue Tier 1 In-Network (INET) ProviderTier 1 Network ProviderPreferred Network Provider and Level 2 Network ProviderParticipating Tier 2 In-Network (INET) ProviderTier 2 Network ProviderIn-Network Provider. / for Home Health and Private Duty Nursing combined. / for Home Health and Private Duty Nursing combined Level 1 Network ProviderValue Tier 1 In-Network (INET) ProviderTier 1 Network ProviderPreferred Network Provider and Level 2 Network ProviderParticipating Tier 2 In-Network (INET) ProviderTier 2 Network ProviderIn-Network Provider. |
|  | Rehabilitation services | Not Applicable | |  | | |  | \*See Therapy Services section |
|  | Habilitation services | Not Applicable | |  | | |  |  |
|  | Skilled nursing care | Not Applicable | |  | | |  | / for Inpatient rehabilitation and skilled nursing services combined. / for Inpatient rehabilitation and skilled nursing services combined for Preferred-Network and In-Network Providers. / for Inpatient rehabilitation and skilled nursing services combined for Non-Network Providers. / for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined. / for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined for Preferred-Network and In-Network Providers. / for Inpatient physical medicine, rehabilitation including day rehabilitation programs and skilled nursing services combined for Non-Network Providers. |
|  | Durable medical equipment | Not Applicable | |  | | |  | \*See Durable Medical Equipment Section |
|  | Hospice services | Not Applicable | |  | | |  | --------none-------- / . / . / In-Network Providers. |
| **If your child needs dental or eye care** | Children’s eye exam | Not covered | | | | Not covered | | Coverage is limited to 1 exam per benefit period for In-Network Providers. \*See Vision Services Section of your evidence of coverage, available in the footnote below. |
|  | Children’s glasses | Not covered | | | | Not covered | | Coverage is limited to 1 unit every 2 years for In-Network Providers. Coverage is limited to $45 maximum benefit per occurrence for Non-Network Providers. \*See Vision Services Section of your evidence of coverage, available in the footnote below. |
|  | Children’s dental check-up | Not covered | | | | Not covered | | Coverage is limited to 2 visits per 12 months for In-Network Providers. |
| **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 |
| **If your child needs dental or eye care** | Children’s eye exam | Not coveredNot Applicable Not covered | | Not covered Not covered | | | Not covered | Coverage is limited to 1 exam per benefit period for In-Network Providers. \*See Vision Services Section of your evidence of coverage, available in the footnote below. |
|  | Children’s glasses | Not coveredNot Applicable Not covered | | Not covered Not covered | | | Not covered | Coverage is limited to 1 unit every 2 years for In-Network Providers. Coverage is limited to $45 maximum benefit per occurrence for Non-Network Providers. \*See Vision Services Section of your evidence of coverage, available in the footnote below. |
|  | Children’s dental check-up | Not coveredNot Applicable Not covered | | Not covered Not covered | | | Not covered | Coverage is limited to 2 visits per 12 months for In-Network Providers. |
| **If your child needs dental or eye care** | Children’s eye exam | Not coveredNot Applicable Not covered | | Not covered Not covered | | | Not covered | \*See Vision Services section |
|  | Children’s glasses | Not coveredNot Applicable Not covered | | Not covered Not covered | | | Not covered |  |
|  | Children’s dental check-up | Not coveredNot Applicable Not covered | | Not covered Not covered | | | Not covered | \*See Dental Services section |

**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**.**)** | | |  |  |
| * AbortionAbortion (except in cases of rape, incest, or when the life of the mother is endangered) * Chiropractic care * Infertility treatment (0-20, 45+) * Services rendered by Non-Network Providers, unless the services are for Emergency Care and emergency ambulance; or the services are approved in advance by Anthem.Services rendered by Providers located outside the Commonwealth of KY, unless the services are for Emergency Care, Urgent Care and ambulance services; or the services are approved in advance by Anthem. * Hearing aids * Non-emergency care when traveling outside the U.S. | * Acupuncture * Cosmetic surgery * Infertility treatment * Long-term care * Spinal Manipulation * Routine eye care (Adult) * Private-duty nursing | * Bariatric Surgery * Dental care (Adult) * Dental care (Pediatric) * Routine foot care unless medically necessaryRoutine foot care * Weight loss programs | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)** | | |  |  |
| * Abortion * Abortion * Bariatric surgery / for morbid obesity only * Bariatric surgery * Dental care (Adult) * Dental care (Adult) * Hearing aids are limited to 1 purchase (including repair/replacement) once every 3 years, In-Network only. * Hearing aids unit every for left ear and unit every for right ear for children 18 years of age or under. $3,000 maximum/hearing aid. * Hearing aids Newborn only. No limit. * Private-duty nursing / Facility Setting only * Private-duty nursing Facility Setting only | * Acupuncture * Acupuncture / Coverage is limited to Pain Management * Acupuncture / * Bariatric surgery for morbid obesity only * Chiropractic care / * Infertility treatment * Hearing aids unit every for left ear and unit every for right ear for children 18 years of age or under. Newborns hearing aids no limit. * Hearing aids unit every for left ear and unit every for right ear for children 18 years of age or under. * Routine eye care (Adult) * Most coverage provided outside the United States. See www.bcbsglobalcore.com | * Acupuncture Coverage is limited to Pain Management * Acupuncture Coverage is limited to Pain Management * Bariatric surgery / * Chiropractic care * Spinal Manipulation * Acupuncture Coverage is limited to Pain Management * Hearing aids-Covered up to age 18. * Hearing aids unit every for left ear and unit every for right ear. Newborns hearing aids no limit. * Hearing aids unit every for left ear and unit every for right ear. * Spinal Manipulation / * Private-duty nursing 2000 hours/benefit period in a Home Setting only * Private-duty nursing 16 hours/benefit period in a Home Setting only   Private-duty nursing 82 visits/calendar year and 164 visits/lifetime in a Home Setting only   * Private-duty nursing 82 visits/calendar year in a Home Setting only * Private-duty nursing Facility Setting no limit and / combined with Home Health * Private-duty nursing / combined with Home Health * Private-duty nursing | | |

**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: Connecticut Department of Insurance, 153 Market Street, 7th Floor, Hartford, CT 06103, (860) 297-3000, (800) 203-3447. Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division 2, Martin Luther King, Jr. Drive, WestTower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, [www.oci.ga.gov/ConsumerService/Home.aspx](http://www.oci.ga.gov/ConsumerService/Home.aspx). Maine Bureau of Insurance, Department of Professional and Financial Regulation, 124 Northern Avenue, Gardiner, ME 04345, (800) 300-5000. New Hampshire Insurance Department, 21 So Fruit St, Suite 14, Concord, NH 03301, Consumer Hotline (800) 852-3416. Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945. New York State Department of Financial Services, One State Street, New York, NY 10004-1511, (800) 342-3736, (212) 480-6400, (518) 474-6600. Nevada Division of Insurance, 1818 E. College Pkwy., Suite 103, Carson City, NV 89706, (775) 687-0700, (888) 872-3234. California Department of Insurance, Consumer Services Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, (800) 927-HELP (4357). Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) HMO-2219. Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490. Missouri Department of Insurance, Consumer Complaints, P.O. Box 690, Jefferson City, MO 65102-0690, (800) 726-7390. Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, (502) 564-3630, (800) 595-6053, (800) 648-6056. Office of the Commissioner of Insurance, 125 South Webster Street, Madison, Wisconsin 53703-3474, (608) 266-3585, (800) 236-8517, (608) 266-3586. State of Indiana Department of Insurance, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204, (800) 622-4461, (317) 232-2395, [www.in.gov/idoi/3008.htm](http://www.in.gov/idoi/3008.htm). Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (800) 686-1526, (614) 644-2673. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://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](https://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](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) for a denial of a [[claim](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/). 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 1038, North Haven, CT 06473-4201ATTN: Grievances and Appeals, P.O. Box 105449, Atlanta, GA 30548-5449ATTN: Grievances and Appeals, P.O. Box 218, North Haven, CT 06473-0218ATTN: Grievances and Appeals, P.O. Box 518, North Haven, CT 06473-0518ATTN: Grievances and Appeals, P.O. Box 27401, Richmond, VA 23279ATTN: Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310ATTN: Grievances and Appeals, P.O. Box 10330, Reno, NV 89520ATTN: Grievances and Appeals, Mail Drop R/6-O, P.O. Box 11825, Albany, NY 12211ATTN: Grievances and Appeals, P.O. Box 1407, Church Street Station, New York, NY 10008-1407ATTN: Grievances and Appeals, 700 Broadway, Mail Stop CO0104-0430, Denver, CO 80273ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

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

Connecticut Department of Insurance, 153 Market Street, 7th Floor, Hartford, CT 06103, (860) 297-3000, (800) 203-3447Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division 2, Martin Luther King, Jr. Drive, WestTower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, [www.oci.ga.gov/ConsumerService/Home.aspx](http://www.oci.ga.gov/ConsumerService/Home.aspx)Maine Bureau of Insurance, Department of Professional and Financial Regulation, 124 Northern Avenue, Gardiner, ME 04345, (800) 300-5000New Hampshire Insurance Department, 21 So Fruit St, Suite 14, Concord, NH 03301, Consumer Hotline (800) 852-3416Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, (800) 552-7945New York State Department of Financial Services, One State Street, New York, NY 10004-1511, (800) 342-3736, (212) 480-6400, (518) 474-6600Nevada Division of Insurance, 1818 E. College Pkwy., Suite 103, Carson City, NV 89706, (775) 687-0700, (888) 872-3234California Department of Insurance, Consumer Services Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, (800) 927-HELP (4357)Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) HMO-2219Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490Missouri Department of Insurance, Consumer Complaints, P.O. Box 690, Jefferson City, MO 65102-0690, (800) 726-7390Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, (502) 564-3630, (800) 595-6053, (800) 648-6056Office of the Commissioner of Insurance, 125 South Webster Street, Madison, Wisconsin 53703-3474, (608) 266-3585, (800) 236-8517, (608) 266-3586State of Indiana Department of Insurance, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204, (800) 622-4461, (317) 232-2395, [www.in.gov/idoi/3008.htm](http://www.in.gov/idoi/3008.htm)Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (800) 686-1526, (614) 644-2673

Connecticut Office of Healthcare Advocate, P.O. Box 1543, Hartford, CT 06144, (866) 466-4446, [www.ct.gov/oha](http://www.ct.gov/oha), [healthcare.advocate@ct.gov](mailto:healthcare.advocate@ct.gov)Georgia Office of Insurance and Safety Fire Commissioner, Consumer Services Division, 2 Martin Luther King, Jr. Drive, West Tower, Suite 716, Atlanta, Georgia 30334, (800) 656-2298, [www.oci.ga.gov/ConsumerService/Home.aspx](http://www.oci.ga.gov/ConsumerService/Home.aspx)Consumers for Affordable Health Care, 12 Church Street, PO Box 2490, Augusta, ME 04338-2490, (800) 965-7476, [www.mainecahc.org](http://www.mainecahc.org), [consumerhealth@mainecahc.org](mailto:consumerhealth@mainecahc.org)Missouri Department of Insurance, 301 W. High Street, Room 830, Harry S. Truman State Office Building, Jefferson City, MO 65101, (800) 726-7390, [www.insurance.mo.gov](file:///C:\Users\TERAFAST-PC\Downloads\www.insurance.mo.gov), [consumeraffairs@insurance.mo.gov](mailto:consumeraffairs@insurance.mo.gov)Office of Consumer Health Assistance, Governor's Consumer Health Advocate, 555 East Washington Ave #4800, Las Vegas, NV 89101, (702) 486-3587, (888) 333-1597, [dhhs.nv.gov/Programs/CHA/](file:///C:\Users\TERAFAST-PC\Downloads\dhhs.nv.gov\Programs\CHA\), [cha@govcha.state.nv.us](mailto:cha@govcha.state.nv.us)Community Service Society of New York, Community Health Advocates, 105 East 22nd Street, 8th floor, New York, NY 10010, (888) 614-5400, [www.communityhealthadvocates.org](http://www.communityhealthadvocates.org), [cha@cssny.org](mailto:cha@cssny.org)California Department of Insurance, Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, 1-800-927-HELP (4357), 1-213-897-8921, 1-800-482-4TDD (4633), [www.insurance.ca.gov/](http://www.insurance.ca.gov/)California Department of Managed Health Care Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814, (888) 466-2219, [www.healthhelp.ca.gov/](http://www.healthhelp.ca.gov/), [helpline@dmhc.ca.gov](mailto:helpline@dmhc.ca.gov)  
  
California Consumer Assistance Program, Operated by the California Department of Managed Health Care, 980 9th St, Suite #500, Sacramento, CA 95814, (888) 466-2219,[www.HealthHelp.ca.gov](http://www.healthhelp.ca.gov/)

**Does this plan provide Minimum Essential Coverage? Yes**

If you don’t have MinimumEssentialCoverage 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? YesNo**

If your plan doesn’t meet the MinimumValueStandards, you may be eligible for a premiumtaxcredit 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.–––––––––––*–––––––––––

image4

**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.

**About these Coverage Examples:**

**Peg is Having a Baby**(9 months of in-network pre-natal care and a hospital delivery)

◼ **The plan’s overall deductible**

◼ **Specialist *copaymentcoinsurance***

◼ **Hospital (facility) *copaymentcoinsurance***

◼ **Other** ***copaymentcoinsurance***

**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** | **$12,800** |

**In this example, Peg would pay:**

|  |  |
| --- | --- |
| ***Cost Sharing*** | |
| **Deductibles** | $250 |
| **Copayments** | $600 |
| **Coinsurance** | $1,200 |
| *What isn’t covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,110** |

**Managing Joe’s type 2 Diabetes**(a year of routine in-network care of a well-controlled condition)

◼ **The plan’s overall deductible**

◼ **Specialist *copaymentcoinsurance***

◼ **Hospital (facility) *copaymentcoinsurance***

◼ **Other** ***copaymentcoinsurance***

**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** | **$7,400** |

**In this example, Joe would pay:**

|  |  |
| --- | --- |
| ***Cost Sharing*** | |
| **Deductibles** | $250 |
| **Copayments** | $2,000 |
| **Coinsurance** | $10 |
| *What isn’t covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$2,320** |

**Mia’s Simple Fracture**(in-network emergency room visit and follow up care)

◼ **The plan’s overall deductible**

◼ **Specialist *copaymentcoinsurance***

◼ **Hospital (facility) *copaymentcoinsurance***

◼ **Other** ***copaymentcoinsurance***

**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** | **$1,900** |

**In this example, Mia would pay:**

|  |  |
| --- | --- |
| ***Cost Sharing*** | |
| **Deductibles** | $250 |
| **Copayments** | $300 |
| **Coinsurance** | $80 |
| *What isn’t covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$630** |

**(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

**Amharic (አማርኛ)፦** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር ይደውሉ።

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**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՝ :

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| image11 | | |
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**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 。

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**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 .

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**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 .

**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 .

**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 .

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

**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 .

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| image19 | | |
| image20 |  | image21 |

**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 .

**Igbo (Igbo):** Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ .

**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 .

**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 .

**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

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

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

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| image33 |  |

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

**Pennsylvania Dutch (Deitsch):** Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff 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 .

**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 .

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**Samoan (Samoa):** Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ‘aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili .

**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 .

**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 .

**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 .

**Thai (ไทย):** หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร เพื่อพูดคุยกับล่าม

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| image42 | . |

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| image43 | | |
| image44 |  | image45 |

**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 .

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| image46 | |
| . | image47 |

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| image48 | . |

**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>](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf). Complaint forms are available at [<http://www.hhs.gov/ocr/office/file/index.html>](http://www.hhs.gov/ocr/office/file/index.html).



**Appendix A**

**Colorado Supplement to the Summary of Benefits and Coverage Form**

|  |  |
| --- | --- |
| Insurance Company Name |  |
| Name of Plan |  |
| 1. Type of Policy | Individual PolicySmall Employer Group PolicyLarge Employer Group Policy |
| 2. Type of plan | Preferred provider organization (PPO)\*  INTERESTED POLICYHOLDERS, CERTIFICATE HOLDERS, AND ENROLLEES ARE HEREBY GIVEN NOTICE THAT THIS SMALL GROUP POLICY REQUIRES THAT AN INSURED TRAVEL OUTSIDE OF THE GEOGRAPHIC AREA TO RECEIVE COVERED HEALTH BENEFITS.  Health maintenance organization (HMO)\*  INTERESTED POLICYHOLDERS, CERTIFICATE HOLDERS, AND ENROLLEES ARE HEREBY GIVEN NOTICE THAT THIS SMALL GROUP POLICY REQUIRES THAT AN INSURED TRAVEL OUTSIDE OF THE GEOGRAPHIC AREA TO RECEIVE COVERED HEALTH BENEFITS.  Provider Point of service (POS) \*Exclusive Provider Organization (EPO) \*Employee Assistance Program (EAP) \* |
| 3. Areas of Colorado where plan is available | Plan is available throughout Colorado.Plan is available only in the following areas: Boulder,El Paso,Teller,Adams,Arapahoe,Broomfield,Clear Creek,Denver,Douglas,Elbert,Gilpin,Jefferson,Park,Fremont,La Plata,Montezuma,Summit,Larimer,WeldPlan is available only in the following areas: PuebloPlan is available only in the following areas: La Plata,Montezuma,Eagle,Summit,ArchuletaPlan is available only in the following areas: Archuleta,Eagle,La Plata,Montezuma,Summit,MesaPlan is available only in the following areas: Boulder,ElPaso,Teller,Adams,Arapahoe,Broomfield,ClearCreek,Denver,Douglas,Elbert,Gilpin,Jefferson,Park,Larimer,Weld,Pueblo,Alamosa,Baca,Bent,Chaffee,Cheyenne,Conejos,Costilla,Crowley,Custer,Fremont,Huerfano,Kiowa,KitCarson,LasAnimas,Lincoln,Logan,Mineral,Morgan,Otero,Phillips,Prowers,RioGrande,Saguache,Sedgwick,Washington,YumaThis means if you live or work outside of the service area where this plan is available, you will have to travel into this service area to receive non-emergency covered services. If you have any questions, please contact Customer Service at . |

**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 | INDIVIDUAL – 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.INDIVIDUAL – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid.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. |
| 5. Out-of-Pocket Maximum | INDIVIDUAL – 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.INDIVIDUAL – 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%.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. |
| 6. What is included in the In- Network Out-of-Pocket Maximum? | Any In-Network Deductible, Copays and Coinsurance on Covered Services, except dental or vision services for members 19 or older. |
| 7. Is pediatric dental covered by this plan? | Yes, pediatric dental is subject to the medical deductible and out-of-pocket.Yes, pediatric dental is subject to a separate deductible and out-of-pocket.Yes, pediatric dental is subject to a separate deductible and medical out-of-pocket.Yes, pediatric dental is covered at 100% of allowable charges. |
| 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: Pap tests, Mammogram Screenings, Prostate Cancer Screenings and Routine colorectal cancer screenings and colonoscopies. |

**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.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 **(888) 231-5046** 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](mailto:dora_insurance@State.co.us)

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