The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Anthem Blue Cross Blue Shield at (800) 542-9402. 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.dol.gov/ebsa/healthreform.com or call (303) 935-2475 or (833) 935-2475 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	PPO and Non-PPO providers combined: $750/individual or $1,500/family	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. PPO preventive care, PPO office visits and urgent care, PPO and Non-PPO hearing services and habilitation services and In-Network outpatient prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	PPO providers: $6,600/individual, $13,200/family (this includes a coinsurance maximum of $2,000/individual, $4,000/family, as well as a $1,500/individual, $3,000/family maximum for in-network prescription drugs). There is also a Non-PPO provider coinsurance maximum of $4,000/individual, $8,000/family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain precertification, health care this plan doesn't cover, charges in excess of benefit maximums, dental and vision plan expenses, and Non-PPO cost sharing except emergency room care for an emergency medical condition.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.anthem.com or call **(800) 542-9402** for a list of PPO 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
		PPO Provider (You will pay the least)	Non-PPO 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	$30 copayment/visit. Deductible does not apply.	40% coinsurance	None.
	Specialist visit	$45 copayment/visit. Deductible does not apply.	40% coinsurance	None.
	Preventive care/screening/ Immunization	No charge. Deductible does not apply.	Not covered	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)	20% coinsurance	40% coinsurance	Professional/physician charges may be billed separately.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Precertification is required to avoid a $200 penalty. Professional/physician charges may be billed separately.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Retail: 20% coinsurance, minimum of $10 copayment/script; Mail Order: $20 copayment/script	Not covered	• Deductible does not apply. • No charge for FDA-approved generic contraceptives (or brand name if a generic is medically inappropriate). • Covers up to a 30-day supply for retail prescription; 31-90 day supply for mail order prescription. • If you select a brand drug when a generic is available, and your provider did not require the brand drug, you will be required to pay the difference between the cost of the brand drug and the generic drug, in addition to any coinsurance or copayments. This amount will not count toward the out-of-pocket limit.
	Preferred brand drugs	Retail: 30% coinsurance, minimum of $20 copayment/script; Mail Order: $40 copayment/script	Not covered	
	Non-preferred brand drugs	Retail: 50% coinsurance, minimum of $40 copayment/script; Mail Order: $80 copayment/script	Not covered	
	Specialty drugs	$75 copayment/script	Not covered	Covers up to a 30-day supply. Deductible does not apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Precertification is required to avoid a $200 penalty.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	You will pay any amount over the allowance for an assistant surgeon fee which will be limited to the maximum of one of the following: • 20% of the allowed charge for the primary surgeon; OR • 10% of the allowed charge for the primary surgeon for a Physician Assistant, surgical assistant or a registered nurse (RN).
If you need immediate medical attention	Emergency room care	$100 copayment/visit, then 20% coinsurance	$100 copayment/visit, then 20% coinsurance	Must be for an emergency medical condition. Copayment is waived if admitted directly from Emergency Room. Professional/physician charges may be billed separately. Non-PPO cost sharing for a non-emergency medical condition does not count toward the PPO out-of-pocket limit.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Must be for an emergency medical condition. Professional/physician charges may be billed separately.
	Urgent care	$45 copayment/visit. Deductible does not apply.	40% coinsurance	Professional/physician charges may be billed separately.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification is required to avoid a $200 penalty. Coverage generally only provided for semi-private room.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	You will pay any amount over the allowance for an assistant surgeon fee which will be limited to the maximum of one of the following: • 20% of the allowed charge for the primary surgeon; OR • 10% of the allowed charge for the primary surgeon for a Physician Assistant, surgical assistant or a registered nurse (RN).
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $30 copayment/visit. Deductible does not apply. Other outpatient services: 20% coinsurance	40% coinsurance	None.
	Inpatient services	20% coinsurance	40% coinsurance	Precertification is required to avoid a $200 penalty. Coverage is generally only provided for semi-private rooms.
If you are pregnant	Office visits	No charge, deductible does not apply.	40% coinsurance	• Depending on the type of services, a copayment, coinsurance, or deductible may apply. • ACA preventive care screenings with a Non-PPO provider are not covered. • Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). • Coverage does not include Lamaze classes.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Precertification is required to avoid a $200 penalty only if hospital stay is longer than 48 hours for vaginal delivery or 96 hours for C-section. Coverage is generally only provided for semi-private room.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Maximum of 100 days/year in lieu of inpatient care or skilled nursing care. Provider must certify initially and periodically.
	Rehabilitation services	20% coinsurance	40% coinsurance	Maximum of 20 visits/year (more than 20 visits in limited circumstances). Precertification is required for inpatient rehabilitation services to avoid a $200 penalty.
	Habilitation services	20% coinsurance. Deductible does not apply.	40% coinsurance. Deductible does not apply.	Maximum of 20 visits/year per type of therapy for congenital defects and birth abnormalities (only for congenital defects as required under State law, including meeting the minimum required coverage for children ages 3-6).
	Skilled nursing care	20% coinsurance	40% coinsurance	Maximum of 60 days/year. Private room covered up to prevailing semi-private room rate in confined area.
	Durable medical equipment	20% coinsurance	40% coinsurance	Rental of equipment is covered unless purchase is less expensive. Replacement allowed once in a 5-year period due to pathological changes or normal growth.
	Hospice services	20% coinsurance	40% coinsurance	Maximum of 8 days/lifetime for respite care and 6 visits for a Licensed/Certified Social Worker (to evaluate the home).
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	If your employer elects to include the optional vision plan, it will be through a separate VSP policy.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	If your employer elects to include the optional dental plan, it will be through a separate Delta Dental policy.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Bariatric Surgery • Cosmetic surgery	• Dental care (Adult and Child) (unless your employer elects to include the optional dental coverage) • Infertility treatment • Long-term care • Private-duty nursing	• Routine eye care (Adult and Child) (unless your employer elects to include the optional vision coverage) • Routine foot care • Weight loss programs (except as required by the health reform law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care (12 visits/person/year)	• Hearing aids (for children under age 18 with hearing loss)	• Non-emergency care when traveling outside the U.S. (if a resident of U.S. and traveling for vacation, business, or schooling)

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-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 a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact CHT Administration at (303) 935-2475 or (833) 935-2475. You may also contact the Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (800) 542-9402.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,760**

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

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$450
Copayments	$210
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,180**

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

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$45**
- **Hospital ER (facility)** **$100 copayment**
  20% coinsurance
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$270
Coinsurance	$150
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,170**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.