



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 (866) 837-4596. 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 <u>providers</u> combined: \$3,200/individual or \$6,400/family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your deductible? | Yes. PPO <u>preventive care</u> (including certain prescription drugs) are covered before you meet your <u>deductible</u> . | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | PPO <u>providers</u> : \$3,200/individual or \$6,400/family. Non-PPO <u>providers</u> : \$5,950/individual or \$11,900/family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the out-of-pocket limit? | <u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain precertification, health care this <u>plan</u> doesn't cover, charges in excess of benefit maximums and dental and vision <u>plan</u> expenses. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |

| | | |
|--|---|--|
| Will you pay less if you use a <u>network provider</u>? | Yes. See www.anthem.com or call (866) 837-4596 for a list of PPO providers. | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u>? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



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 <u>provider's office</u> or clinic | Primary care visit to treat an injury or illness | No charge | 20% <u>coinsurance</u> | Other cost shares may apply depending on services provided. |
| | <u>Specialist</u> visit | No charge | 20% <u>coinsurance</u> | Other cost shares may apply depending on services provided. |
| | <u>Preventive care/screening/Immunization</u> | No charge. <u>Deductible</u> does not apply. | Not covered | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No charge | 20% <u>coinsurance</u> | Professional/physician charges may be billed separately. Costs may vary by site of service. |
| | Imaging (CT/PET scans, MRIs) | No charge | 20% <u>coinsurance</u> | Members are responsible for confirming pre-authorizations are on file with Anthem. A \$200 penalty will apply if prior authorization is not obtained. Costs may vary by site of service. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medimpact.com | Generic drugs | No charge | Not covered | <ul style="list-style-type: none"> • <u>Deductible</u> does not apply to <u>preventive care</u> drugs that are required to be covered under health reform. • Covers up to a 30-day supply for retail prescription; 31 to 90-day supply for mail order prescription. |
| | Preferred brand drugs | No charge | Not covered | |
| | Non-preferred brand drugs | No charge | Not covered | |
| | <u>Specialty drugs</u> If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medimpact.com | Drug Eligible for SaveOn; If member enrolls, no member cost share. If member does not enroll, for Essential Drugs \$0 after deductible. For Non-Essential Drugs | Not covered | Covers up to a 30-day supply. |

| 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) | |
| | | member responsible for full cost and does not accumulate to Out-of-Pocket Maximum. Drugs Not Eligible for SaveOn; \$0 after deductible. | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | 20% <u>coinsurance</u> | Members are responsible for confirming pre-authorizations are on file with Anthem. A \$200 penalty will apply if prior authorization is not obtained. |
| | Physician/surgeon fees | No charge | 20% <u>coinsurance</u> | 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: <ul style="list-style-type: none"> • 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 | <u>Emergency room care</u> | No charge | 20% <u>coinsurance</u> | Must be for an <u>emergency medical condition</u> . Professional/physician charges may be billed separately. |
| | <u>Emergency medical transportation</u> | No charge | 20% <u>coinsurance</u> | Must be for an <u>emergency medical condition</u> . Professional/physician charges may be billed separately. |
| | <u>Urgent care</u> | No charge | 20% <u>coinsurance</u> | Professional/physician charges may be billed separately. Other cost shares may apply depending on services provided. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 20% <u>coinsurance</u> | Members are responsible for confirming pre-authorizations are on file with Anthem. A \$200 penalty will apply if prior authorization is not obtained. Coverage generally only provided for semi-private room. |
| | Physician/surgeon fees | No charge | 20% <u>coinsurance</u> | 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: <ul style="list-style-type: none"> • 20% of the allowed charge for the primary surgeon; OR |

| 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) | |
| | | | | <ul style="list-style-type: none"> 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 | No charge | 20% <u>coinsurance</u> | None. |
| | Inpatient services | No charge | 20% <u>coinsurance</u> | Members are responsible for confirming pre-authorizations are on file with Anthem. A \$200 penalty will apply if prior authorization is not obtained. Coverage is generally only provided for semi-private rooms. |
| If you are pregnant | Office visits | No charge. <u>Deductible</u> does not apply. | 20% <u>coinsurance</u> | <ul style="list-style-type: none"> Depending on the type of services, a <u>copayment</u>, <u>coinsurance</u>, or <u>deductible</u> may apply. ACA <u>preventive care screenings</u> with a Non-PPO <u>provider</u> 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 | No charge | 20% <u>coinsurance</u> | Members are responsible for confirming pre-authorizations are on file with Anthem. A \$200 penalty will apply if prior authorization is not obtained. 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 | No charge | 20% <u>coinsurance</u> | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No charge | 20% <u>coinsurance</u> | Maximum of 100 days/year in lieu of inpatient care or <u>skilled nursing care</u> . <u>Provider</u> must certify initially and periodically. |
| | <u>Rehabilitation services</u> | No charge | 20% <u>coinsurance</u> | Maximum of 20 visits/year (more than 20 visits in limited circumstances). Members are responsible for confirming pre-authorizations are on file with Anthem. A \$200 penalty will apply if prior authorization is not obtained. |
| | <u>Habilitation services</u> | No charge | 20% <u>coinsurance</u> | 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). |

| 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) | |
| | <u>Skilled nursing care</u> | No charge | 20% <u>coinsurance</u> | Maximum of 60 days/year. Private room covered up to prevailing semi-private room rate in confined area. |
| | <u>Durable medical equipment</u> | No charge | 20% <u>coinsurance</u> | 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. |
| | <u>Hospice services</u> | No charge | 20% <u>coinsurance</u> | 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 or Alpha 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 <u>excluded services</u> .) | | |
|--|---|---|
| <ul style="list-style-type: none"> Acupuncture Cosmetic surgery Dental care (Adult and Child) (unless your employer elects to include the optional dental coverage) | <ul style="list-style-type: none"> Long-term care Private-duty nursing | <ul style="list-style-type: none"> 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.) | | |
| <ul style="list-style-type: none"> Chiropractic care (12 visits/person/year) Bariatric Surgery | <ul style="list-style-type: none"> Hearing aids (for children under age 18 with hearing loss) Infertility treatment | <ul style="list-style-type: none"> 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: Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490, Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform, or contact Anthem at the number on the back of your ID card. 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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al (866) 837-4596.

—————*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 \$3,200
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$3,200 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$10 |
| The total Peg would pay is | \$3,210 |

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

- The plan's overall deductible \$3,200
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$3,200 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$3,220 |

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

- The plan's overall deductible \$3,200
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,900 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,900 |