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 877-811-3106. 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?	$1,000/individual or $2,000/family for In-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network preventive care, In-Network office visits, hearing services, In-Network urgent care, In-Network 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?	$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).	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. 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 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 877-811-3106 for a list of Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-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	$30 copayment/visit. Deductible does not apply.	Not covered	Other cost shares may apply depending on services provided.
	Specialist visit	$45 copayment/visit. Deductible does not apply.	Not covered	Other cost shares may apply depending on services provided.
	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	Not covered	Professional/physician charges may be billed separately. Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Members are responsible for confirming pre-authorizations are on file with Anthem. Costs may vary by site of service.

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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medimpact.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 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 MedImpact Assist Specialty Cost Containment Program; if member qualifies, partial funding or 100% funding with no member cost share. If member does not qualify, for Essential Drugs $75 Copay. For Non- Essential Drugs member responsible for full cost and does not accumulate to Out-of- Pocket Maximum. Drugs Not Eligible for MedImpact Assist Specialty Cost Containment Program; $75 Copay	Not covered	Pharmaceutical manufacturers may sponsor MAPS and/or PAPs and charitable foundation assistance programs, which provide financial assistance to certain qualifying individuals. MedImpact or its subcontractor shall communicate directly with Client's Eligible Members identified by MedImpact to obtain required financial information from each Eligible Member necessary for MedImpact to perform its review. Such review will yield one of the following three outcomes for each Eligible Member identified by MedImpact: A. No Funding: The Eligible Member does not qualify for a MAP or a PAP, or charitable foundation assistance programs; the Eligible Member's standard specialty benefit, including any Copayment amount will apply. B. Partial Funding: The Eligible Member qualifies for and MedImpact secures a portion of the total costs of the drug from the MAP and/or PAP, or a charitable foundation assistance program. C. 100% Funding: The Eligible Member qualifies for, and MedImpact secures 100% funding to cover

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)	
				the total cost of the drug from the MAP and/or PAP, or a charitable foundation assistance program; the Eligible Member has $0 cost-share obligation.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Members are responsible for confirming pre-authorizations are on file with Anthem.
	Physician/surgeon fees	20% coinsurance	Not covered	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	Covered as In-Network	Must be for an emergency medical condition. Copayment is waived if admitted directly from Emergency Room. Professional/physician charges may be billed separately. Non-Network cost sharing for a non-emergency medical condition does not count toward the PPO out-of-pocket limit.
	Emergency medical transportation	20% coinsurance	Covered as In-Network	Must be for an emergency medical condition. Professional/physician charges may be billed separately.
	Urgent care	$45 copayment/visit. Deductible does not apply.	Covered as In-Network	Professional/physician charges may be billed separately. Other cost shares may apply depending on services provided.

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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Members are responsible for confirming pre-authorizations are on file with Anthem. Coverage generally only provided for semi-private room.
	Physician/surgeon fees	20% coinsurance	Not covered	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	Not covered	None.
	Inpatient services	20% coinsurance	Not covered	Members are responsible for confirming pre-authorizations are on file with Anthem. Coverage is generally only provided for semi-private rooms.
If you are pregnant	Office visits	No charge, deductible does not apply.	Not covered	• Depending on the type of services, a copayment, coinsurance, or deductible may apply. • ACA preventive care screenings with a Non-Network 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	Not covered	Members are responsible for confirming pre-authorizations are on file with Anthem. 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	Not covered	

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)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Maximum of 100 days/year in lieu of inpatient care or skilled nursing care. Provider must certify initially and periodically.
	Rehabilitation services	20% coinsurance	Not covered	Maximum of 20 visits/year (more than 20 visits in limited circumstances). Members are responsible for confirming pre-authorizations are on file with Anthem.
	Habilitation services	20% coinsurance. Deductible does not apply.	Not covered	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	Not covered	Maximum of 60 days/year. Private room covered up to prevailing semi-private room rate in confined area.
	Durable medical equipment	20% coinsurance	Not covered	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	Not covered	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 excluded services.)

- Acupuncture
- Cosmetic surgery
- Long-term care
- Private-duty nursing
- Dental care (Adult and Child) (unless your employer elects to include the optional dental coverage)
- 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) • Bariatric Surgery	• Hearing aids • Infertility treatment	• 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** **$1,000**
- **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	$1,000
Copayments	$0
Coinsurance	$1,980
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,990**

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

- **The plan's overall deductible** **$1,000**
- **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** **$1,000**
- **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	$1,000
Copayments	$270
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,370**

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