




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, <https://eoc.anthem.com/eocdps/fi>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (800) 542-9402 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$500 /single or \$1,000 /family for In- Network Providers . \$1,200 /single or \$2,400 /family for Non- 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. Preventive care and Prescription Drugs for Non- 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/ .
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 ?	\$3,000 /single or \$6,000 /family for In- Network Providers . \$6,000 /single or \$12,000 /family for Non- Network Providers .	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 ?	Pre-Authorization Penalties, Premiums , balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes, PPO. See www.anthem.com or call (800) 542-9402 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 .
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 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
		Designated In-Network Provider In-Network Tier1	In-Network Provider In-Network Tier2	Non-Network Provider Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10/visit then 15% coinsurance for non-laboratory and non-x-ray services	15% coinsurance	35% coinsurance	-----none-----
	Specialist visit	\$10/visit then 15% coinsurance for non-laboratory and non-x-ray services	15% coinsurance	35% coinsurance	-----none-----
	Preventive care/screening/immunization	No charge	No charge	Office: No charge Facility: \$500 copayment	There may be other levels of cost share that are contingent on how services are provided. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab & X-ray – Office 10% coinsurance Lab & X-ray – Hospital 15% coinsurance		Lab – Office 35% coinsurance X-Ray – Office 35% coinsurance	Costs may vary by site of service.
	Imaging (CT/PET scans, MRIs)	Free-standing facility - 10% coinsurance Hospital based – 15% coinsurance		35% coinsurance	Costs may vary by site of service.
If you need drugs to treat your illness or condition	Tier 1 - Typically Generic	\$10/prescription (retail/home delivery)		Not covered	Precertification may be required for certain Prescription Drugs. Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or
	Tier 2 - Typically Preferred / Brand	\$40/prescription (retail) \$80/prescription (home delivery)		Not covered	

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/fi>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Designated In-Network Provider In-Network Tier1	In-Network Provider In-Network Tier2	Non-Network Provider Out-of-Network	
More information about prescription drug coverage is available at http://www.anthem.com/pharmacyinformation/	Tier 3 - Typically Non-Preferred / Specialty Drugs	\$60/prescription (retail) \$120/prescription (home delivery)		Not covered	through the Home Delivery (Mail Order) Pharmacy. *See Prescription Drug Section of your evidence of coverage, available in the footnote below. Retail copay includes a 30-day supply; Home delivery copay includes a 90-day supply.
	Tier 4 - Typically Specialty (brand and generic)	30% coinsurance up to \$125/prescription 30-day (retail/home delivery) and \$250/prescription 90-day (home delivery)		Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery Center – 10% coinsurance Hospital based facility – 15% coinsurance		35% coinsurance	Costs may vary by site of service.
	Physician/surgeon fees	Ambulatory Surgery Center – 10% coinsurance Hospital based facility – 15% coinsurance		35% coinsurance	-----none-----
If you need immediate medical attention	Emergency room care	15% coinsurance		Covered as In-Network	Coinsurance waived if admitted.
	Emergency medical transportation	15% coinsurance		Covered as In-Network	There may be other levels of cost share that are contingent on how services are provided.
	Urgent care	15% coinsurance		35% coinsurance	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance		35% coinsurance	30 day limit/calendar year for Inpatient Rehabilitation.
	Physician/surgeon fees	15% coinsurance		35% coinsurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance		Office Visit 35% coinsurance Other Outpatient 35% coinsurance	-----none-----
	Inpatient services	15% coinsurance		35% coinsurance	-----none-----
If you are pregnant	Office visits	\$150 copayment/prenatal office visit/delivery from Doctor	15% coinsurance	35% coinsurance	In-Network: 15% coinsurance for all non-lab and non-x-ray services.

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/fi>.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Designated In-Network Provider In-Network Tier1	In-Network Provider In-Network Tier2	Non-Network Provider Out-of-Network	
	Childbirth/delivery professional services	15% coinsurance		35% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	15% coinsurance		35% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge		35% coinsurance	100 visits/year for In- Network Providers .
	Rehabilitation services	15% coinsurance		35% coinsurance	Outpatient coverage for physical, occupational and speech therapies is limited to 60 visits combined per calendar year In and Out-of-Network combined. Cardiac Rehabilitation is limited to 36 visits per calendar year In and Out-of-Network combined.
	Habilitation services	15% coinsurance		35% coinsurance	Habilitation visits count towards your rehabilitation limit.
	Skilled nursing care	15% coinsurance		35% coinsurance	60 day limit/year. In and Out-of-Network combined
	Durable medical equipment	15% coinsurance		35% coinsurance	-----none-----
	Hospice services	No charge		35% coinsurance	Costs may vary by site of service.
If your child needs dental or eye care	Children's eye exam		Not covered	Not covered	-----none-----
	Children's glasses		Not covered	Not covered	-----none-----
	Children's dental check-up		Not covered	Not covered	-----none-----

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/fi>.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Infertility treatment
- Private-duty nursing
- Weight loss programs
- Cosmetic surgery
- Long- term care
- Routine eye care (adult)
- Dental care (adult)
- [Preauthorization](#) - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. To find out which services require Preauthorization and to be sure that Preauthorization has been given, you may contact us.
- Routine foot care unless you have been diagnosed with diabetes.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture (limits apply)
- Hearing aids (limits apply)
- Bariatric Surgery (limits apply)
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Chiropractic care (limits apply)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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. 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:

ATTN: Grievances and Appeals, 700 Broadway, Mail Stop CO0104-0430, Denver, CO 80273

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

Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/fi>.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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

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

About these Coverage Examples:



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

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$150
■ Hospital (facility) copayment	15%
■ Other coinsurance	15%

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	\$12,840
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$150
Coinsurance	\$1,829
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,479

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$10
■ Hospital (facility) copayment	15%
■ Other coinsurance	15%

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	\$7,460
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$150
Coinsurance	\$1,022
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,672

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

■ The plan's overall deductible	\$500
■ Specialist copayment	\$10
■ Hospital (facility) copayment	15%
■ Other coinsurance	15%

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	\$2,010
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$60
Coinsurance	\$227
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$787

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(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 (800) 542-9402

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 542-9402 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (800) 542-9402.

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՝ (800) 542-9402:

Bassa (Bàsɔ́ Wùdù): M̐ dyi dyi-diè-dɛ̀ bɛ́ bédé b́a céè-dɛ̀ nìà kɛ dyí ní, ɔ̀ m̀ò nì dyí-bédɛ̀n-dɛ̀ bɛ́ m̐ kɛ gbo-kpá-kpá kè b̐́ kp̐́ dɛ́ m̐ bídí-wùdùùn b́ó pídyi. B́é m̐ kɛ wuɖu-zìin-nyò d̀ò gbo wùdù kɛ, d́á (800) 542-9402.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (800) 542-9402 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (800) 542-9402 သို့ ခေါ်ဆိုပါ။

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 (800) 542-9402。

Dinka (Dinka): Na nɔŋ thiëc në ke de yā thorë, ke yin nɔŋ lonj bë yi kuony ku wër alëu bë gɛɛr yic yin ne thonj du ke cin wëu tääüë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cöl (800) 542-9402.

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 (800) 542-9402.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (800) 542-9402 تماس بگیرید.

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 (800) 542-9402.

Language Access Services:

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 (800) 542-9402.

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 (800) 542-9402.

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 (800) 542-9402.

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 (800) 542-9402.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (800) 542-9402 ।

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 (800) 542-9402.

Igbo (Igbo): O bụrụ na ị nwere ajuju o bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ o bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (800) 542-9402.

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 (800) 542-9402.

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 (800) 542-9402.

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 (800) 542-9402

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(800) 542-9402 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (800) 542-9402 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (800) 542-9402.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (800) 542-9402 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັກກັບລ່າມເປພາສາ, ໃຫ້ໂທຫາ (800) 542-9402.

Navajo (Diné): Díí naaltsoos biká'ígíí lahgo bina'idíłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjį bee níl hodoonih t'áadoo báąh ilinígóó. Ata' halne'ígíí la' bich'i' hadeesdzih nínízingo kojį' hodiłnih (800) 542-9402.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (800) 542-9402

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (800) 542-9402 bilbilla.

Pennsylvania Dutch (Deutsch): Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (800) 542-9402 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 (800) 542-9402.

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 (800) 542-9402.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (800) 542-9402 ਤੇ ਕਾਲ ਕਰੋ।

Language Access Services:

Romanian (Română): Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (800) 542-9402.

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (800) 542-9402.

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 totagi. Ina ia talanoa i se tagata faaliliu, vili (800) 542-9402.

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 (800) 542-9402.

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 (800) 542-9402.

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 (800) 542-9402.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (800) 542-9402 เพื่อพูดคุยกับล่าม

Ukrainian (Українська): якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером: (800) 542-9402.

Urdu (اردو): اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (800) 542-9402 پر کال کریں۔

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 (800) 542-9402.

(Yiddish) (אידיש): אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (800) 542-9402.

Yoruba (Yorùbá): Tí o bá ní èyíkéyí ibèrè nípa àkọsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọfẹ́fẹ́. Bá wa ògbùfọ́ kan sọrọ́, pe (800) 542-9402.

Language Access Services:

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>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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Appendix A

Colorado Supplement to the Summary of Benefits and Coverage Form

Insurance Company Name	Anthem Blue Cross and Blue Shield
Name of Plan	CHEIBA Prime Blue Priority PPO Plan
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Preferred Provider Organization (PPO)*
3. Areas of Colorado where plan is available	Plan is available throughout Colorado.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Notice: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	<p>SINGLE – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by [2] or more individuals.</p>
5. Out-of-Pocket Maximum	<p>SINGLE – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met.</p> <p>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.</p>

*Network access plans are available on request at the Member Services number on your member ID card or can be obtained by going to www.anthem.com/co/networkaccess.

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6. What is included in the In- Network Out-of-Pocket Maximum?	Most In-Network Copays and Coinsurance. Not included in the Out-of-Pocket Maximum for this plan are Pre-Authorization Penalties, Services in excess of allowed benefit (benefit cap), Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.
7. Is pediatric dental covered by this plan?	No, the plan does not include pediatric dental.
8. What cancer screenings are covered?	The following screenings are covered under your benefits subject to the terms and conditions of your certificate of coverage: Pap Tests, Mammogram Screenings, Prostate Cancer Screenings, and Colorectal Cancer Screenings.

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, 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 (800) 542-9402 or visit us at <http://www.anthem.com>

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance:

Consumer Services, Life and Health Section

1560 Broadway, Suite 850, Denver, CO 80202

Call: 303-894-7490 (in-State, toll-free: 800-930-3745)

Email: dora_insurance@State.co.us

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (800) 542-9402.