




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/](http://www.healthcare.gov/sbc-glossary/) or call (800) 542-9402 to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| What is the overall <a href="#">deductible</a> ?                                | <b>\$2,500</b> /single or <b>\$5,000</b> /family for In- <a href="#">Network Providers</a> .<br><b>\$2,500</b> /single or <b>\$5,000</b> /family for Non- <a href="#">Network Providers</a> .  | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay. In-Network and Out-of-Network deductibles are separate and do not count towards each other.   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> for In- <a href="#">Network</a> and Non- <a href="#">Network providers</a> .  | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .  |
| Are there other <a href="#">deductibles</a> for specific services?              | No.  | You don't have to meet <a href="#">deductibles</a> for specific services.  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | <b>\$3,500</b> /single or <b>\$7,000</b> /family for In- <a href="#">Network Providers</a> .<br><b>\$7,000</b> /single or <b>\$14,000</b> /family for Non- <a href="#">Network Providers</a> . | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met. In-Network and Out-of-Network Out-of-Pocket are separate and do not count towards each other.  |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Pre-Authorization Penalties, <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                                      | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .  |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes, PPO. See <a href="http://www.anthem.com">www.anthem.com</a> or call (800) 542-9402 for a list of <a href="#">network providers</a> .  | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an out-of- <a href="#">network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of- <a href="#">network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |

|  |     |  |
|--|-----|--|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No. | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . |
|--|-----|--|

 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<br>(You will pay the least)            | Non-Network Provider<br>(You will pay the most)           |   |
| If you visit a health care <a href="#">provider's</a> office or clinic   | Primary care visit to treat an injury or illness                                    | 15% <a href="#">coinsurance</a>                            | 35% <a href="#">coinsurance</a>                           | -----none-----  |
|  | <a href="#">Specialist</a> visit  | 15% <a href="#">coinsurance</a>                            | 35% <a href="#">coinsurance</a>                           | -----none-----  |
|  | <a href="#">Preventive care</a> / <a href="#">screening</a> /immunization           | No charge  | \$80/visit; \$500 copayment for covered facility services | 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 <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.   |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)                                 | 15% <a href="#">coinsurance</a>                            | 35% <a href="#">coinsurance</a>                           | -----none-----  |
|  | Imaging (CT/PET scans, MRIs)  | 15% <a href="#">coinsurance</a>                            | 35% <a href="#">coinsurance</a>                           | -----none-----  |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.anthem.com/pharmacyinformation/">http://www.anthem.com/pharmacyinformation/</a><br>Essential | Tier 1 - Typically Generic  | 15% <a href="#">coinsurance</a> (retail and home delivery) | 35% <a href="#">coinsurance</a> (retail)                  | 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. Retail includes a 30-day supply; Home delivery includes a 90-day supply. |
|  | Tier 2 - Typically <a href="#">Preferred</a> / Brand                                | 15% <a href="#">coinsurance</a> (retail and home delivery) | 35% <a href="#">coinsurance</a> (retail)                  |   |
|  | Tier 3 - Typically Non- <a href="#">Preferred</a> / <a href="#">Specialty Drugs</a> | 15% <a href="#">coinsurance</a> (retail and home delivery) | 35% <a href="#">coinsurance</a> (retail)                  |   |
|  | Tier 4 - Typically <a href="#">Specialty</a> (brand and generic)                    | 15% <a href="#">coinsurance</a> (retail and home delivery) | 35% <a href="#">coinsurance</a> (retail)                  |   |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)                                      | 15% <a href="#">coinsurance</a>                            | 35% <a href="#">coinsurance</a>                           | -----none-----  |
|  | Physician/surgeon fees  | 15% <a href="#">coinsurance</a>                            | 35% <a href="#">coinsurance</a>                           | -----none-----  |
| If you need immediate medical attention  | <a href="#">Emergency room care</a>   | 15% <a href="#">coinsurance</a>                            | Covered as In- <a href="#">Network</a>                    | -----none-----  |
|  | <a href="#">Emergency medical transportation</a>                                    | 15% <a href="#">coinsurance</a>                            | Covered as In- <a href="#">Network</a>                    | -----none-----  |
|  | <a href="#">Urgent care</a>   | 15% <a href="#">coinsurance</a>                            | 35% <a href="#">coinsurance</a>                           | -----none-----  |

\* 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   |
|---|---|---|---|--|
|   |   | In-Network Provider<br>(You will pay the least)     | Non-Network Provider<br>(You will pay the most)     |  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)        | 15% <a href="#">coinsurance</a>                     | 35% <a href="#">coinsurance</a>                     | Up to 30 inpatient rehab days per calendar year. Services from In- <a href="#">Network Provider</a> and Non- <a href="#">Network Provider</a> count towards your limit.        |
|   | Physician/surgeon fees                    | 15% <a href="#">coinsurance</a>                     | 35% <a href="#">coinsurance</a>                     | -----none-----   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Office Visit<br>15% <a href="#">coinsurance</a>     | Office Visit<br>35% <a href="#">coinsurance</a>     | Office Visit<br>-----none-----   |
|   |   | Other Outpatient<br>15% <a href="#">coinsurance</a> | Other Outpatient<br>35% <a href="#">coinsurance</a> | Other Outpatient<br>-----none-----   |
|   | Inpatient services                        | 15% <a href="#">coinsurance</a>                     | 35% <a href="#">coinsurance</a>                     | -----none-----   |
|   |   | 15% <a href="#">coinsurance</a>                     | 35% <a href="#">coinsurance</a>                     | -----none-----   |
| If you are pregnant   | Office visits                             | 15% <a href="#">coinsurance</a>                     | 35% <a href="#">coinsurance</a>                     | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).  |
|   | Childbirth/delivery professional services | 15% <a href="#">coinsurance</a>                     | 35% <a href="#">coinsurance</a>                     |  |
|   | Childbirth/delivery facility services     | 15% <a href="#">coinsurance</a>                     | 35% <a href="#">coinsurance</a>                     |  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 15% <a href="#">coinsurance</a>                     | Not covered   | 100 visits/calendar year for In- <a href="#">Network Providers</a> .   |
|   | <a href="#">Rehabilitation services</a>   | 15% <a href="#">coinsurance</a>                     | 35% <a href="#">coinsurance</a>                     | 20 visits for Physical Therapy/calendar year. 20 visits for Occupational Therapy/calendar year. 20 visits for Speech Therapy/calendar year. Costs may vary by site of service. |
|   | <a href="#">Habilitation services</a>     | 15% <a href="#">coinsurance</a>                     | 35% <a href="#">coinsurance</a>                     | Habilitation visits count towards your rehabilitation limit.   |
|   | <a href="#">Skilled nursing care</a>      | 15% <a href="#">coinsurance</a>                     | 35% <a href="#">coinsurance</a>                     | 100 day limit/calendar year.   |
|   | <a href="#">Durable medical equipment</a> | 15% <a href="#">coinsurance</a>                     | Not covered   | -----none-----   |
|   | <a href="#">Hospice services</a>          | 15% <a href="#">coinsurance</a>                     | 35% <a href="#">coinsurance</a>                     | -----none-----   |
| 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)
- 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.
- Bariatric surgery
- Infertility treatment
- Private-duty nursing
- Weight loss programs
- Cosmetic surgery
- Long-term care
- Routine eye care (adult)

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

- Acupuncture (limits apply)
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Chiropractic care (limits apply)
- Hearing Aids (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](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](http://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](http://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](#).

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

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,500 |
| ■ <a href="#">Specialist coinsurance</a>                        | 15%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 15%     |
| ■ Other <a href="#">coinsurance</a>                             | 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 |
|--------------------|----------|

In this example, Peg would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,500        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$1,000        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$3,500</b> |

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,500 |
| ■ <a href="#">Specialist coinsurance</a>                        | 15%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 15%     |
| ■ Other <a href="#">coinsurance</a>                             | 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 |
|--------------------|---------|

In this example, Joe would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,500        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$744          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$3,244</b> |

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$2,500 |
| ■ <a href="#">Specialist coinsurance</a>                        | 15%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 15%     |
| ■ Other <a href="#">coinsurance</a>                             | 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 |
|--------------------|---------|

In this example, Mia would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,010        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,010</b> |

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



**(TTY/TDD: 711)**

[illegible]

**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 (Bàsɔ̀ Wùdù):** M̃ dyi dyi-diè-dɛ bɛ̀ bédé bá cée-dɛ nìà kɛ dyí ní, ɔ̀ mò nì dyí-bédɛ̀n-dɛ bɛ̀ m̃ kɛ gbo-kpá-kpá kè bɔ̃ kpɔ́ dɛ̀ m̃ bídí-wùdù̀n bó pídyi. Bɛ̀ m̃ kɛ wudu-zìn-nyò dò gbo wùdù kɛ, d́á (800) 542-9402.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে 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 ဖုန်း (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 thiēc nē ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wər alēu bē gēer yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te kər yin ba jam wēnē ran ye thok geryic, ke yin cəl (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 هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره 9402-542 (800) تماس بگیرید.

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## 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 તમે કોઈપણ પ્રશ્ન અથવા માહિતી માટે પૂછવા માંગો છો, તો તમે મફત સહાયતા અને માહિતી માટે અમારા ભાષા સેવા સેન્ટરનો સંપર્ક કરી શકો છો. અમારા ભાષા સેવા સેન્ટરનો સંપર્ક કરવા માટે, કૃપા કરીને (800) 542-9402 નંબર પર કૉલ 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 (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):** Ọ bụr ụ na ị nwere ajuju 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 (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.  
ເພື່ອໄດ້ຊ່ວຍກັນລ່າມແບບພາສາ, ໃຫ້ໂທຫາ (800) 542-9402.

**Navajo (Diné):** Díí naaltsoos biká'ígíí lahgo bina'idíłkidgo ná bohónéedzá 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' hodiłilnih (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 ògbùfọ̀ kan sọrọ̀, 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 Health Savings Account Compatible 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](http://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.<br>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](mailto: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.