**Summary of Benefits and Coverage:** What this **Plan** Covers & What You Pay For Covered Services **Coverage Period: 07/01/2021– 06/30/2022**

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| **Anthem Blue Cross and Blue Shield**  **Community Colleges Blue Priority 1 – Essential Rx** | **Coverage for:** Individual + Family | **Plan Type: HMO** |

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| image2 | **The Summary of Benefits and Coverage (SBC) document will help you choose a health** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)**. The SBC shows you how you and the** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **would share the cost for covered health care services. NOTE: Information about the cost of this** [[**plan**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **(called the** [[**premium**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/)**) 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](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[balance billing](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[coinsurance](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[copayment](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[deductible](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), [[provider](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/), or other underlined terms see the Glossary. You can view the Glossary at [[www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/)](http://www.healthcare.gov/sbc-glossary/) or call (800) 542-9402 to request a copy. | |

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| **Important Questions** | **Answers** | **Why This Matters:** |
| **What is the overall deductible?** | **$1,000**/single or **$3,000**/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. Preventive care and Prescription Drugs for In-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/>](https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| **Are there other deductibles for specific services?** | Yes. **$150**/person or **$300**/family for In-Network Providers for Prescription Drug. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | **$4,000**/single or **$8,000**/family for In-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, Blue Priority HMO. 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?** | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

| image3 | All [[**copayment**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) and [[**coinsurance**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) costs shown in this chart are after your [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) has been met, if a [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) applies. |
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| **Common**  **Medical Event** | **Services You May Need** | **What You Will Pay** | | **Limitations, Exceptions, & Other Important Information** |
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| **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 | $15/visit medical deductible does not apply | Not covered | There may be other levels of cost share that are contingent on how services are provided. |
| Specialist visit | $45/visit medical deductible does not apply | Not covered | There may be other levels of cost share that are contingent on how services are provided. |
| Preventive care**/**screening**/**  immunization | No charge | 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) | Office Lab – No copayment  (100% covered);  Office X-Ray - $45/visit;  Hospital Lab/X-Ray –  $200/procedure plus 20% coinsurance | Not covered | Costs may vary by site of service. |
| Imaging (CT/PET scans, MRIs) | Office Imaging –  $200/procedure;  Hospital Imaging –  $200/procedure plus 20% coinsurance | Not covered | 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 <http://www.anthem.com/pharmacyinformation/> | Tier1 - Typically Generic | $15/prescription pharmacy deductible does not apply (retail/home delivery) | Not covered | Retail includes a 30-day supply; Mail Order includes a 90-day supply.  Tier 2 and Tier 3 outpatient drugs are subject to a $150 deductible per individual or a $300 deductible per family, once satisfied then services are subject to the copayment.  Certain specialty drugs must be ordered through a specialty pharmacy; see the contract plan for details.  Specialty drugs are not eligible for the 90 day Mail Order program. |
| Tier2 - Typically Preferred / Brand | $40/prescription (retail) and $80/prescription (home delivery) | Not covered |
| Tier3 - Typically Non-Preferred / Specialty Drugs | $60/prescription (retail) and $120/prescription (home delivery) | Not covered |
| Tier4 - Typically Specialty Drugs | 30% copay up to $350/prescription (retail) and $350/prescription (home delivery)  deductible does not apply | Not covered |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Ambulatory Surgery Center – $200/admission;  Hospital – $200/admission then 20% coinsurance | Not covered | Costs may vary by site of service. |
| Physician/surgeon fees | Ambulatory Surgery Center – No copayment  (100% Covered);  Hospital – 20% coinsurance | Not covered | Costs may vary by site of service. |
| **If you need immediate medical attention** | Emergency room care | $250/visit medical deductible does not apply | Covered as In-Network | Copay waived if admitted. |
| Emergency medical transportation | 20% coinsurance for ground | Covered as In-Network | --------none-------- |
| Urgent care | $45/visit medical deductible does not apply | Covered as In-Network | See separate benefit for diagnostic test services. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $200/admission then 20% coinsurance | Not covered | Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 150 days combined per benefit period. |
| Physician/surgeon fees | 20% coinsurance | Not covered |  |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office Visit  $15/visit medical deductible does not apply  Other Outpatient  20% coinsurance | Office Visit  Not covered  Other Outpatient  Not covered | --------none-------- |
| Inpatient services | $200/admission then 20% coinsurance | Not covered | --------none-------- |
| **If you are pregnant** | Office visits | $100/pregnancy for prenatal care office visits | Not covered | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
| Childbirth/delivery professional services | No charge | Not covered |
| Childbirth/delivery facility services | $200/admission plus 20% coinsurance | Not covered |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | Not covered | 100 visits/benefit year for In-Network Providers. |
| Rehabilitation services | $15/visit medical deductible does not apply | Not covered | \*See Therapy Services section |
| Habilitation services | $15/visit medical deductible does not apply | Not covered |
| Skilled nursing care | 20% coinsurance | Not covered | Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 150 days combined per benefit period. |
| Durable medical equipment | 50% coinsurance | Not covered | --------none-------- |
| Hospice services | No charge | Not covered | --------none-------- |
| **If you need dental or eye care** | Eye exam | $15/visit | Maximum $35 reimbursement | Covers 1 routine refraction exam every 12 months |
| Glasses | Not covered | Not covered |
| Dental check-up | Not covered | Not covered | --------none-------- |

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| **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**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/).**)** |
| |  |  |  | | --- | --- | --- | | * Abortion (except in cases of rape, incest, or when the life of the mother is endangered) | * Bariatric surgery | * Cosmetic surgery | | * Dental care (adult) | * Dental Check-up | * Glasses for a child | | * Hearing aids (adult) | * Infertility treatment | * Long- term care | | * Non-emergency care when traveling outside the U.S. | * 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. | * Private-duty nursing | | * Routine foot care unless you have been diagnosed with diabetes. | * Weight loss programs |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |

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| **Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)** |
| |  |  |  |  | | --- | --- | --- | --- | | * Acupuncture (limits apply) | * Chiropractic care (limits apply | Emergency coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com) |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |

**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: Department of Labor’s Employee Benefits Security Administration at (866) 444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](https://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](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) for a denial of a [[claim](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/). 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](https://www.dol.gov/ebsa/healthreform)

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

**Does this plan provide Minimum Essential Coverage? Yes**

If you don’t have MinimumEssentialCoverage 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 MinimumValueStandards, you may be eligible for a premiumtaxcredit 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:**

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| image4 | **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. |

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| **Peg is Having a Baby**  (9 months of in-network pre-natal care and a hospital delivery) | |  | **Managing Joe’s type 2 Diabetes**  (a year of routine in-network care of a well- controlled condition) | |  | **Mia’s Simple Fracture**  (in-network emergency room visit and follow up care) | |
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|  **The** [[**plan’s**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **overall** [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) | **$1,000** |  |  **The** [[**plan’s**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **overall** [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) | **$1,000** |  |  **The** [[**plan’s**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) **overall** [[**deductible**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) | **$1,000** |
|  **Per Pregnancy OV *copayment*** | **$100** |  |  [[**Specialist**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) ***copayment*** | **$45** |  |  [[**Specialist**](https://www.healthcare.gov/sbc-glossary/)](https://www.healthcare.gov/sbc-glossary/) ***copayment*** | **$45** |
|  **Hospital (facility) *copayment*** | **$200** |  |  **Hospital (facility) *copayment*** | **$200** |  |  **Hospital (facility) *copayment*** | **$250** |
|  **Other** ***coinsurance*** | **20%** |  |  **Other** ***coinsurance*** | **20%** |  |  **Other** ***coinsurance*** | **20%** |
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| **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)* | |  | **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)* | |  | **This EXAMPLE event includes services like:**  **Emergency room care** *(including medical supplies)*  **Diagnostic test** *(x-ray)*  **Durable medical equipment** *(crutches)*  **Rehabilitation services** *(physical therapy)* | |
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| **Total Example Cost** | **$12,840** |  | **Total Example Cost** | **$7,460** |  | **Total Example Cost** | **$2,010** |
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| **In this example, Peg would pay:** |  |  | **In this example, Joe would pay:** |  |  | **In this example, Mia would pay:** |  |
| ***Cost Sharing*** | |  | ***Cost Sharing*** | |  | ***Cost Sharing*** | |
| **Deductibles** | $1,000 |  | **Deductibles** | $150 |  | **Deductibles** | $603 |
| **Copayments** | $345 |  | **Copayments** | $3,245 |  | **Copayments** | $854 |
| **Coinsurance** | $2,299 |  | **Coinsurance** | $0 |  | **Coinsurance** | $225 |
| *What isn’t covered* | |  | *What isn’t covered* | |  | *What isn’t covered* | |
| Limits or exclusions | $60 |  | Limits or exclusions | $55 |  | Limits or exclusions | $0 |
| **The total Peg would pay is** | **$3,704** |  | **The total Joe would pay is** | **$3,450** |  | **The total Mia would pay is** | **$1,682** |

**(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።

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| .(800) 542-9402 | image5 |

**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:

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| image6 | |
| image7 | (800) 542-9402. |

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| image8 | | |
| image9 | (800) 542-9402 | image10 |

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| image11 | | |
| image12 | (800) 542-9402 | image13 |

**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。

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| image14 | |
| image15 | (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.

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| image16 | | |
| image17 | (800) 542-9402 | image18 |
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**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.

**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.

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| image20 | (800) 542-9402 | image21 |

**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 ajụjụ 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

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| image23 | (800) 542-9402 | image24 |

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| image26 | (800) 542-9402 | image27 |

**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.

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| image29 | (800) 542-9402. |

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| image32 | |
| image33 | (800) 542-9402 |

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

**Pennsylvania Dutch (Deitsch):** Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Helfe 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.

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**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 totogi. 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

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**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.

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**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>](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf). Complaint forms are available at [<http://www.hhs.gov/ocr/office/file/index.html>](http://www.hhs.gov/ocr/office/file/index.html).

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**Colorado Supplement to the Summary of Benefits and Coverage Form**

**Anthem BlueCross BlueShield**

**Blue Priority 1 15-200-80% $150D-$15/40/60/30% ESS**

**TYPE OF COVERAGE**

|  |  |
| --- | --- |
| 1. Type of plan | Health maintenance organization (HMO) |
| 2. Out-of-network care covered?1 | Only for emergency and urgent care. |
| 3. Areas of Colorado where plan is available | Plan is available only in the following areas: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Elbert, Fremont, Jefferson, La Plata, Larimer, Mesa, Montrose, Montezuma, Pueblo, Summit, Teller, and Weld. |

**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** | **What this means** |
| 4. Deductible Period | Benefit Year | Benefit year deductibles restart each July 1. |
| 5. Annual Deductible Type | Individual/Family | “Individual” means the deductible amount you and each individual covered by the plan will have to pay for allowable covered expenses before the carrier will cover these expenses. "Family" is the maximum deductible amount that is required to be met for all family members covered by the plan. It may be an aggregated amount (e.g. $3000 per family) or specified and the number of individual deductibles that must be met (e.g. “3 deductibles per family”). |
| 6. What cancer screenings  are covered? | The following screenings are covered under your benefits subject to the terms and conditions of your certificate of coverage: . | |

**LIMITATIONS AND EXCLUSIONS**

|  |  |
| --- | --- |
| 7. Period during which pre-existing  conditions are not covered for  covered persons age 19 and older? 2 | Not applicable; plan does not impose limitation periods for pre-existing conditions. |
| 8. How does the policy define a "pre-existing  condition”? | Not applicable. Plan does not exclude coverage for pre-existing conditions. |
| 9. Exclusionary Riders: Can an  individual’s specific, pre-existing  conditions be entirely excluded from  the policy? | No |

**USING THE PLAN**

|  |  |  |
| --- | --- | --- |
|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| 10. If the provider charges more for a  covered service than the plan  normally pays, does the enrollee  have to pay the difference? | No | Yes, out-of network care is not covered except as noted. |
| 11. Does the plan have a binding  arbitration clause? | Yes. | |

**Questions:** Call **(800) 542-9402** or visit us at www.anthem.com

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

Colorado Division of Insurance

Consumer Affairs Section

1560 Broadway, Suite 850

Denver, CO 80202

Call 303-894-7490 (in-state toll-free 800-830-3745)

Email: [[insurance@dora.state.co.us](mailto:insurance@dora.state.co.us)](mailto:insurance@dora.state.co.us)

If you need assistance to understand this document in Spanish, you may request it at no additional cost by calling the customer service number above.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número que aparece arriba.

**Endnotes**

**1** "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that this plan may

require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it

may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2 Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion

period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.