Anthem Blue Cross and Blue Shield
BlueClassic 10 15/40/60/30%

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 – 12/31/2017
Coverage for: Individual + Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://eoc.anthem.com/eocdps/fi or by calling (855) 333-5735.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** single / **$4,500** family for In-Network Providers. Does not apply to Primary Care visit, Preventive care, Prescription Drugs, and Specialist visit. **$3,000** single / **$9,000** family for Out-of-Network Providers. Does not apply to Preventive care.	You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. There is a separate $150 deductible per individual or $300 deductible per family for outpatient Tier 2 or Tier 3 prescription drugs.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; **$3,500** single / **$8,500** family for In-Network Providers. **$7,000** single / **$17,000** family for Out-of-Network Providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Pre-Authorization Penalties, Premiums, Balance-Billed 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**.

Questions: Call (855) 333-5735 or visit us at www.anthem.com
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (855) 333-5735 to request a copy.

Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, PPO. For a list of In-Network providers, see www.anthem.com or call **(855) 333-5735**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No; you do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 9. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit	30% coinsurance after deductible	--------none--------
	Specialist visit	$50 copay per visit	30% coinsurance after deductible	--------none--------
	Other practitioner office visit	Spinal Manipulation $25 copay per visit Acupuncture $25 copay per visit	Spinal Manipulation Not covered Acupuncture Not covered	Spinal Manipulation Coverage for In-Network Providers is limited to 20 visits per year. Deductible does not apply to In-Network providers. Acupuncture and Massage Therapy visits count towards your chiropractic limit Acupuncture Deductible does not apply to In-Network providers. Coverage is limited to 20 visits per year combined for Acupuncture and

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
				Massage Therapy
	Preventive care/screening/immunization	No charge	$50 / visit $500 copayment for covered facility services	There may be other levels of cost share that are contingent on how services are provided.
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 10% coinsurance after deductible X-Ray – Office 10% coinsurance after deductible	Lab – Office 30% coinsurance after deductible X-Ray – Office 30% coinsurance after deductible	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	30% coinsurance after deductible	--------none--------
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 copay per prescription (retail only) and $37.50 copay per prescription (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) Specialty drug network must be used for In-network coverage. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days.
	Tier2 - Typically Preferred / Brand	$40 copay per prescription (retail only) and $120 copay per prescription (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) Specialty drug network must be

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
				used for In-network coverage.
	Tier3 - Typically Non-Preferred / Specialty Drugs	$60 copay per prescription (retail only) and $180 copay per prescription (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) Specialty drug network must be used for In-network coverage.
	Tier4 - Typically Specialty Drugs	30% coinsurance up to $250 per prescription (retail only)	Not covered	Covers up to a 30 day supply (retail pharmacy) Specialty drug network must be used for In-network coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	30% coinsurance after deductible	--------none--------
	Physician/surgeon fees	10% coinsurance after deductible	30% coinsurance after deductible	--------none--------
If you need immediate medical attention	Emergency room services	10% coinsurance after deductible	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	10% coinsurance after deductible for ground	Covered as In-Network	--------none--------
	Urgent care	$50 copay per visit	30% coinsurance after deductible	Deductible does not apply to In-Network providers. Costs may vary by site of service.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	30% coinsurance after deductible	Coverage for In-Network Providers and Non-Network

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
				Providers combined is limited to 30 day limit per calendar Year for Inpatient Rehabilitation.
	Physician/surgeon fee	10% coinsurance after deductible	30% coinsurance after deductible	--------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit $25 copay per visit Mental/Behavioral Health Facility Visit - Facility Charges 10% coinsurance after deductible	Mental/Behavioral Health Office Visit 30% coinsurance after deductible Mental/Behavioral Health Facility Visit - Facility Charges 30% coinsurance after deductible	Mental/Behavioral Health Office Visit Deductible does not apply to In-Network providers. Mental/Behavioral Health Facility Visit - Facility Charges --------none--------
	Mental/Behavioral health inpatient services	10% coinsurance after deductible	30% coinsurance after deductible	--------none--------
	Substance use disorder outpatient services	Substance Use Office Visit $25 copay per visit Substance Use Facility Visit - Facility Charges 10% coinsurance after deductible	Substance Use Office Visit 30% coinsurance after deductible Substance Use Facility Visit - Facility Charges 30% coinsurance after deductible	Substance Use Office Visit Deductible does not apply to In-Network providers. Substance Use Facility Visit - Facility Charges --------none--------
	Substance use disorder inpatient services	10% coinsurance after deductible	30% coinsurance after deductible	--------none--------
If you are pregnant	Prenatal and postnatal care	$50 copay	30% coinsurance after deductible	Your doctor's charge for delivery are part of prenatal and postnatal care Deductible does

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
				not apply to In-Network providers. Costs may vary by site of service.
	Delivery and all inpatient services	10% coinsurance after deductible	30% coinsurance after deductible	Applies to inpatient facility. Other cost shares may apply depending on services provided.
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	Not covered	Coverage for In-Network Providers is limited to 100 visits per year.
	Rehabilitation services	10% coinsurance after deductible	30% coinsurance after deductible	Coverage is limited to 20 visits per year for Physical Therapy. Coverage is limited to 20 visits per year for Occupational Therapy. Coverage is limited to 20 visits per year for Speech Therapy. Apply to In-Network Providers and Non-Network Providers combined. Costs may vary by site of service. Habilitation visits count towards your rehabilitation limit.
	Habilitation services	10% coinsurance after deductible	30% coinsurance after deductible	Coverage is limited to 20 visits per year for Physical Therapy.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
				Coverage is limited to 20 visits per year for Occupational Therapy. Coverage is limited to 20 visits per year for Speech Therapy. Apply to In-Network Providers and Non-Network Providers combined. Costs may vary by site of service. Habilitation visits count towards your rehabilitation limit.
	Skilled nursing care	10% coinsurance after deductible	30% coinsurance after deductible	Coverage for In-Network Providers and Non-Network Providers combined is limited to 100 day limit per year.
	Durable medical equipment	10% coinsurance after deductible	Not covered	--------none--------
	Hospice service	No charge	30% coinsurance after deductible	--------none--------
If your child needs dental or eye care	Eye exam	Not covered	Not covered	--------none--------
	Glasses	Not covered	Not covered	--------none--------
	Dental check-up	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Hearing aids Except for children up to age 18; 1 every 5 years.
- Infertility treatment
- Long- term care
- 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 eye care (adult)
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Spinal Manipulation
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (855) 333-5735. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy <u>does</u> provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage <u>does</u> meet the minimum value standard for the benefits it provides.**

Language Access Services:

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

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

About These Coverage Examples:

These examples show how this plan might cover
medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,445
- **Patient pays** $2,095

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$90
Coinsurance	$355
Limits or exclusions	$150
Total	$2,095

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,472
- **Patient pays** $1,928

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$137
Copays	$1,751
Coinsurance	$0
Limits or exclusions	$40
Total	$1,928

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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 (855) 333-5735

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 333-5735 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 (855) 333-5735.

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՝ (855) 333-5735:

Bassa (Bǎsɔ́ɔ̀ Wùdù): Mˋ dyi dyi-diè-dɛ̀ bě bédé bá céè-dɛ̀ nià kɛ dyí ní, ɔ mɔ̀ nì dyí-bɛ̀dɛ̀ìn-dɛ̀ bɛ́ m̀ ké gbo-kpá-kpá kè bɔ̌ kpɔ̃ dé m̀ bídí-wùdùǔn bó pídyi. Bé m̀ ké wudu-zììn-nyɔ̀ dò gbo wùdù kɛ, dá (855) 333-5735.

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 (855) 333-5735 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အခမဲ့အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (855) 333-5735 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 (855) 333-5735。

Dinka (Dinka): Na nɔŋ thiëëc në ke de yä thorë, ke yin nɔŋ loŋ bë yi kuony ku wɛr alëu bë gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kɔr yin ba jam wënë ran ye thok geryic, ke yin cɔl (855) 333-5735.

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 (855) 333-5735.

Farsi (فارسي): 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 (855) 333-5735 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 (855) 333-5735.

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 (855) 333-5735.

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 (855) 333-5735.

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 (855) 333-5735.

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 (855) 333-5735.

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 (855) 333-5735 ।

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 (855) 333-5735.

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 (855) 333-5735.

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 (855) 333-5735.

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 (855) 333-5735.

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 (855) 333-5735

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、(855) 333-5735 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (855) 333-5735 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (855) 333-5735.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (855) 333-5735 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄຳຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມກັບລ່າມແປພາສາ, ໃຫ້ໂທຫາ (855) 333-5735.

Navajo (Diné): Díí naaltsoos bikáʼígíí łahgo bínaʼídiłkidgo ná bohónéedzą́ dóó bee ahóótʼiʼ tʼáá ni nizaad kʼehjí bee nił hodoonih tʼáadoo bą́ą́h íłínígóó. Ataʼ halneʼígíí łaʼ bichʼį́ʼ hadeesdzih nínízingo kojį́ʼ hodíilnih (855) 333-5735.

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 (855) 333-5735

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (855) 333-5735 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 (855) 333-5735 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 (855) 333-5735.

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 (855) 333-5735.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 333-5735 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 (855) 333-5735.

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. (855) 333-5735.

Samoan (Samoa): Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou ʻaia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (855) 333-5735.

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 (855) 333-5735.

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 (855) 333-5735.

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 (855) 333-5735.

Thai (ไทย): หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (855) 333-5735 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: (855) 333-5735.

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، (855) 333-5735 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 (855) 333-5735.

(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 (855) 333-5735.

Yoruba (Yorùbá): Tí o bá ní èyíkéyìí ìbèrè nípa àkọsílẹ̀ yìí, o ní ẹ̀tọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ lọ́fẹ̀ẹ́. Bá wa ògbùfọ̀ kan sọ̀rọ̀, pe (855) 333-5735.

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Anthem BlueCross BlueShield

Colorado Supplement to the Summary of Benefits and Coverage Form
Anthem BlueCross BlueShield
BlueClassic 10 RX ded $150/$300 15/40/60/30%

TYPE OF COVERAGE

1. Type of plan	Preferred provider organization (PPO)
2. Out-of-network care covered?[1]	Yes, but patient pays more for out-of-network care.
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	What this means
4. Deductible Period	Calendar Year	Calendar year deductibles restart each January 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: colorectal cancer screening, PapTest, MammogramScreenings, and Prostate cancer screenings.	

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, 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.
11. Does the plan have a binding arbitration clause?	Yes.	

Questions: Call **(855) 333-5735** 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

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.