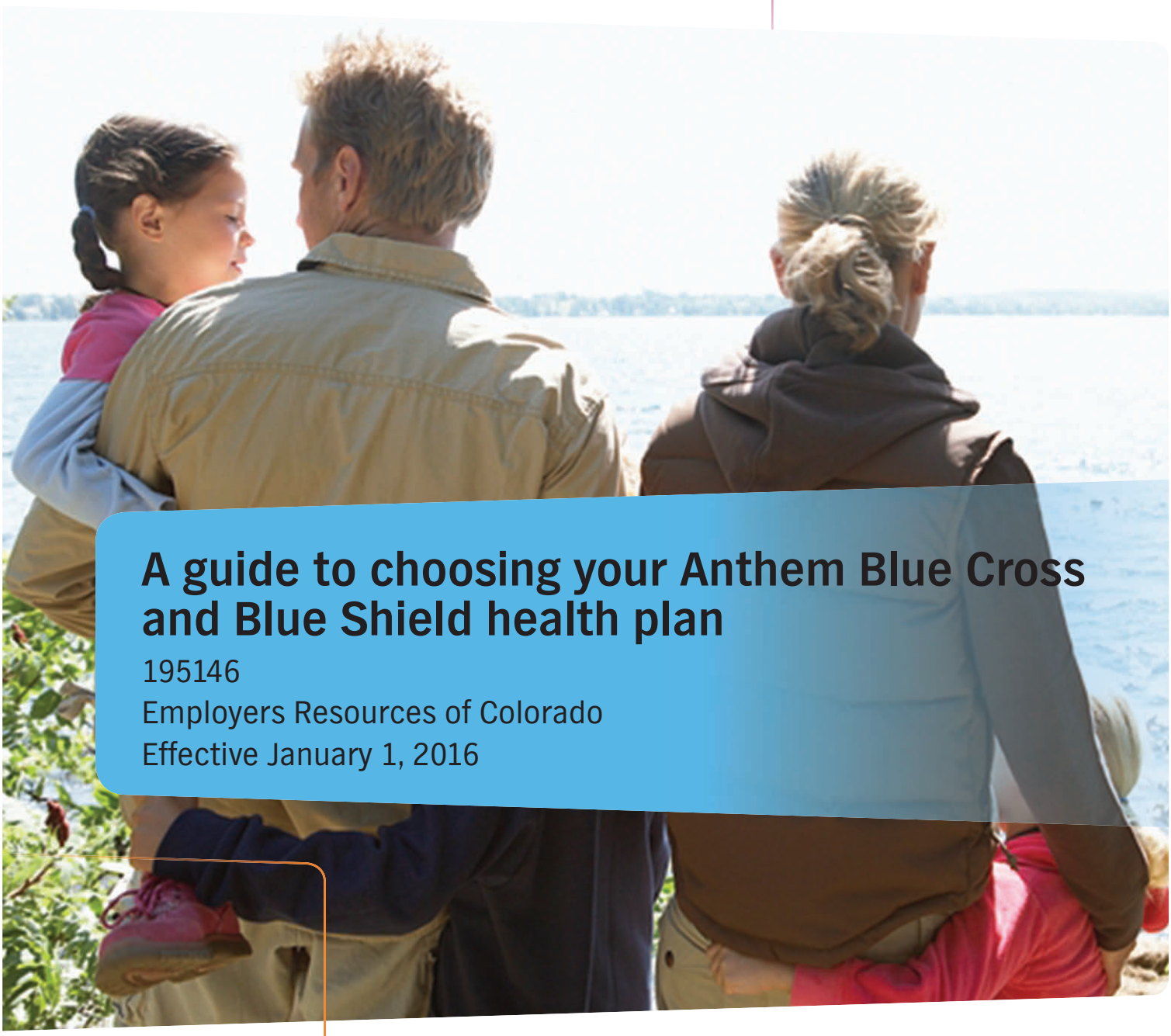
Anthem BlueCross BlueShield



# A guide to choosing your Anthem Blue Cross and Blue Shield health plan

195146

Employers Resources of Colorado

Effective January 1, 2016

This guide is information only. You must enroll to be covered.

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Anthem BlueCross BlueShield

# An Anthem Blue Cross and Blue Shield ID card means something

It means you have access to quality care from quality doctors. It means you can always get your questions answered. It means you have our support before you ever need health care. And that's what this guide is for. We want you to have everything you need to make a good decision.

**We're also giving you a personalized Enrollment Resource webpage where you can:**

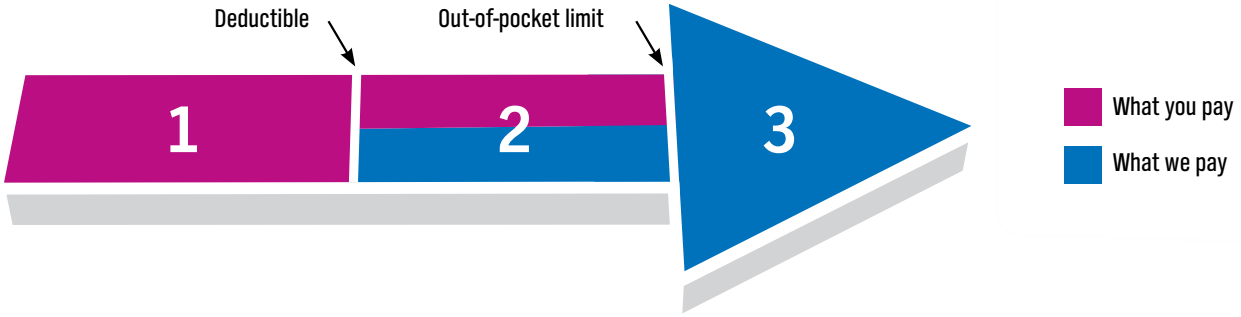
- Watch an interactive video with helpful tips on selecting a plan.
- View and save a digital version of this guide.
- Find a doctor in your network.
- View your full plan details.

View your enrollment resources at http://enrollment.anthem.com/ERC.

# Getting started with health insurance

Let's start with how health insurance works in general

How most health plans work




1. **You pay your deductible.** This is a set amount that you pay before your plan starts paying for covered services. If your plan has **copays** (flat fees like $30 for each visit) along with a deductible, you only need to pay the copay for most doctor visits.
2. **After you meet your deductible, you and your plan share the cost of covered services.** You pay a copay or coinsurance (a percentage of the cost) each time you get care. Your insurance covers the rest.
3. **You're protected by your plan's out-of pocket limit.** That's the most you pay for covered health services each year. With some plans, you still have copays even after you reach your out-of-pocket limit.
    - What about the money for health insurance that gets deducted from your paycheck? That's your premium. Think of it like a membership fee. It's separate from what you pay when you get care.
    - Remember, this chart is only an example. Your actual costs will depend on the type of plan you choose, the service you get and the doctor. To see your actual costs, please refer to your plan information.

# Choose a health plan that works for you

Invest in your health with the right health plan.

The doctors, hospitals and other health care providers in our network have agreed to charge lower rates for our members.

## HMO

**Health Maintenance Organization.** It's a type of health plan where you only get care from a network of doctors in your area. You'll need to choose a main doctor, also called a primary care doctor, from the HMO network. If you need a specialist, you'll most likely have to go through your primary care doctor to get a referral.

Visit anthem.com/HMObasics to watch a video explaining the basics of an HMO.

Some HMO plans may have different rules. So be sure to check your plan details.

## PPO

**Preferred Provider Organization.** This type of plan covers services from almost any doctor or hospital, but you get a discount if you use a provider from the PPO network. You pay more if you go to a doctor who's not in the PPO network. You don't usually need a referral from your main doctor, also called a primary care doctor, to see a specialist.

Visit anthem.com/PPObasics to watch a video explaining the basics of a PPO.

Some PPO plans may have different rules. So be sure to check your plan details.

## HSA

**Health Savings Account.** This is an account where you put money in and use the funds to pay for future health care—like your deductible and coinsurance. If you use up the funds before you reach your deductible, you pay for care until you reach the deductible. After that, your plan works much like a PPO — you pay a percentage of the cost for care until you reach your out-of-pocket maximum. People who don't have a lot of health problems often end up not using all the money in their account. So they end up not paying anything out of pocket.

Visit anthem.com/HSAbasics to watch a video explaining the basics of an HSA.

# More coverage for you

When you enroll, you'll probably need to opt-in for the coverage options in this section.

## Dental

Dental coverage not only protects your teeth, but can support overall health, too. Some conditions like heart disease, for example, have warning signs in the mouth and gums. That's why quality dental coverage is an important part of your insurance package.

## Vision

With Blue View Vision℠, you have access to a network of over 30,000 doctors and more than 25,000 locations across the country, including convenient retail stores like LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical and most Pearle Vision® stores.

Your new vision coverage includes a routine eye exam, frames and either eyeglass lenses or contact lenses.

My Anthem ID card means I have access to quality care from quality doctors

# More coverage for you

When you enroll, you'll probably need to opt-in for the coverage options in this section.

## Life

Anthem life insurance protects your family if something should happen to you. But it also goes far beyond just making a needed benefit payment, including:

- Resource Advisor offers support in other ways, including face-to-face counseling, creating a will, help if you're a victim of identity theft, legal visits and financial counseling — at no extra cost.
- Travel assistance gives you access to emergency medical and travel services if you're traveling more than 100 miles from home.
- Other benefits can include an early payment to you if you face a terminal illness and elect it. Your family also may get an additional payment if your death or certain injuries are caused by an accident.
- Help for your beneficiary if you should pass away, including grief counseling, legal visits and financial counseling.

# Frequently asked questions (FAQs)

You can register at anthem.com – your simple and convenient solution to managing your health

## Can I keep my current doctor?

Yes, you can. But keep in mind that you get the most out of your plan if your doctor is part of the network. Some plans cover only services from network doctors, which means you pay for the full cost if you see a doctor outside the network. Other plans cover services from doctors outside the network — but your plan pays more of the cost when you see a network doctor. Be sure to check the details of your plan.

To find out if your doctor is in our network, or to find a new doctor or pharmacy in our network, go to our ***Find a Doctor*** tool on anthem.com. You can search by specialty and check a doctor's training, certifications and member reviews. Be ready to enter your plan name to view the network that serves your plan. You can also use ***Find a Doctor*** on your smartphone.

## What prescription drugs are covered?

View the drugs we cover at www.anthem.com/national4tier.

And here's a tip: you'll often pay less for generic versions of higher-cost name brand drugs.

To learn more about pharmaceutical programs that may apply to your coverage, check out the Customer Support section on anthem.com. Then go to FAQs > Pharmacy.

## How do I enroll?

Your employer has chosen an alternative enrollment process rather than using our standard enrollment form. Your Benefits Administrator or Human Resources Representative will be able to provide you with plan enrollment instructions.

## How do I use my health plan when I need care?

After you enroll, your member ID card will come in the mail. Be sure to bring it with you to the doctor.

## Is preventive care covered?

Yes, preventive care from a network provider is covered at 100%. It's very important to take care of your health with regular checkups even when you feel fine. So talk to your doctor about screenings and immunizations that you may need to protect your health.

## Can I manage my health care on the Web?

Yes. As soon as you become a member, you'll be able to register at anthem.com. It's designed to help you manage your health care and your coverage simply and conveniently. Many of our members find these self-service tools helpful:

- Check on your claims.
- Find a doctor or pharmacy.
- Check the price of a drug and refill a prescription.
- Track your health care spending.
- Compare quality and costs at hospitals and other facilities.
- Go paperless.
- Take your Health Assessment to learn about your health risks so you can address them.

Download the free anthem.com mobile app so you can manage your health care on the go!

Visit **anthem.com/guidedtour** to watch a video explaining how our website can help you.

## Do I have health and wellness benefits with my plan?

Yes. In fact, we have a set of tools and resources that can help you reach your health goals. They can also save you money on products and services for your health. Just go to anthem.com and click the Health & Wellness tab. Once you're a member, you can log in and see more.

Check out these health and wellness programs your employer is providing in addition to your health insurance benefits:

**24/7 NurseLine** — Our registered nurses can answer your health questions wherever you are — any time, day or night.

**Future Moms** — Moms-to-be get personalized support and guidance from registered nurses to help them have a healthy pregnancy, a safe delivery and a healthy baby.

**ConditionCare** — Get the added support you may need if you have asthma, diabetes, heart disease, chronic obstructive pulmonary disease or heart failure. A nurse coach can answer questions about your health and help you reach your health

# Frequently asked questions (FAQs)

goals based on your doctor's care plan. You can work with dietitians, health educators, pharmacists and social workers to reach those goals and feel your best.

**ComplexCare** — If you have a serious health condition or a number of health issues that need extra care, a nurse coach will help answer your questions, work to coordinate your care, and help you effectively use your health benefits.

**MyHealth Coach** — Get one-on-one professional advice from an experienced health coach for yourself or your family. Topics range from general wellness information to more serious issues like a chronic illness or help with medications.

**Healthy Lifestyles** — Take charge of your total wellness through a personalized Well-Being Plan and custom trackers that help you manage your physical and mental health.

**Behavioral Health Resource** — Work with licensed mental health professionals who are available 24/7 to help you deal with behavioral health issues.

**Staying Healthy Reminders** — An annual reminder sent to your home will recommend important preventive health screenings or treatments based on age or gender.

## How can my plan help me save money?

You'll save money every time you go to a doctor in network — they've agreed to charge lower rates for Anthem members. But we'll also help save you money before you go to the doctor.

At anthem.com, you can compare how much a medical procedure will cost at different locations. Plus, all members get discounts on health-related products.

**Home Delivery Pharmacy** — You can save money and time by having your prescriptions delivered to your home. Learn how to get started with Home Delivery.

**Cost and Quality** — If you're getting an imaging test (like an X-ray), a sleep test, colonoscopy orendoscopy, we'll work with you and your doctor to give you choices so you can find quality facilities at low prices.

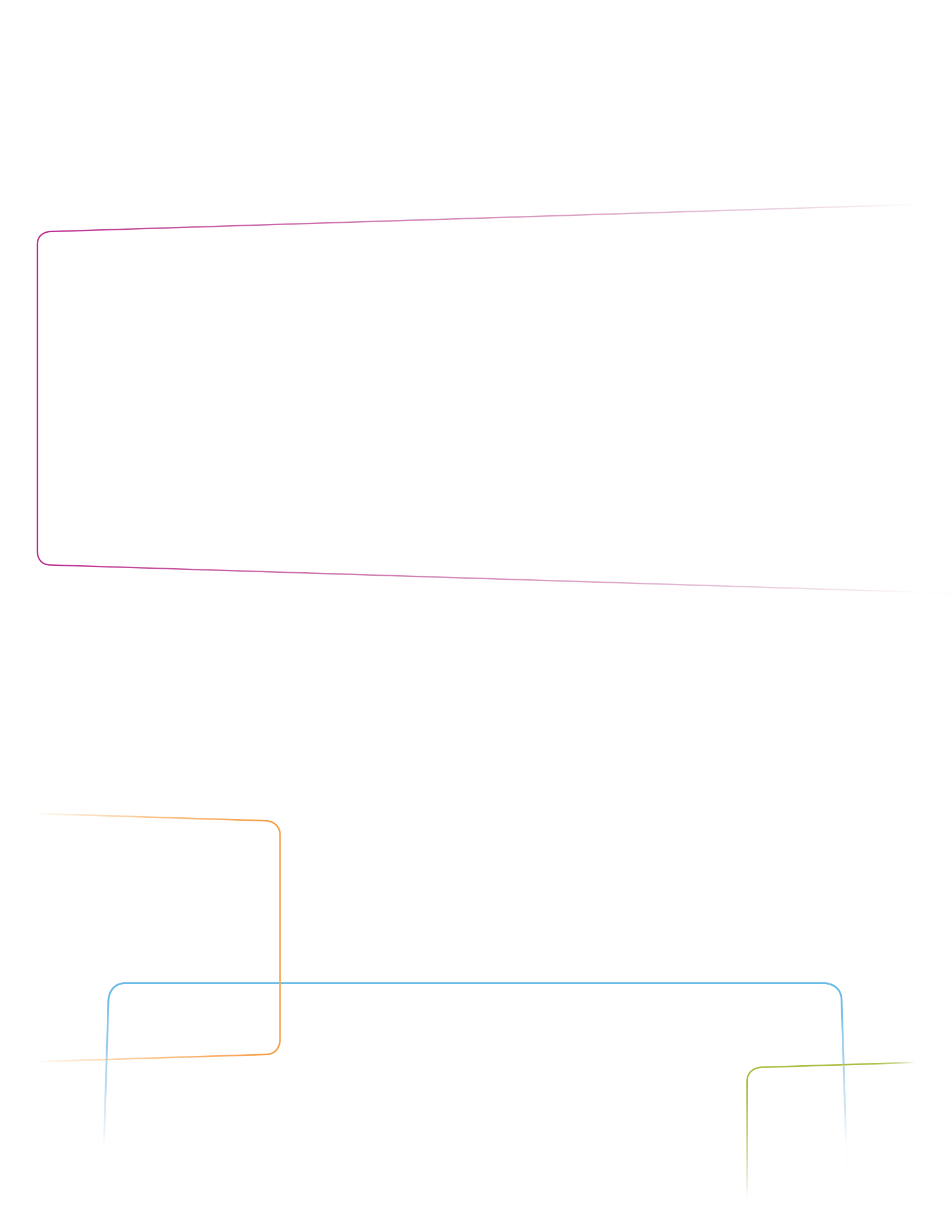
**Anthem Health Rewards** — Reward yourself for healthy behavior. Get valuable incentives if you participate in wellness programs or condition management programs.

**LiveHealth Online®** - Connect to doctors without appointments, waiting rooms or high costs. All you need is a computer, web cam and Internet connection. You'll enjoy immediate, live-video doctor visits with your choice of U.S. board-certified doctors — any day of the year. Enroll today for free at **livehealthonline.com**.

**Enhanced Personal Health Care** — We're helping doctors focus on the quality of care they give. They'll know your history, your specialists and your medications, and they'll coordinate your treatment with other doctors and health care providers. And, they'll get you the care you need when you need it, even after hours.

# Your plan details

In this next section, you'll find more information about your plan.



**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 1-877-811-3106.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For In-Network: **$1,000** Individual/**$3,000** Family Deductible does not apply to preventive care or copayments. | You must pay all the 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 2 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 $200 deductible per individual or $400 deductible per family for outpatient Tier 2 or Tier 3 prescription drugs. | 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. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. For In-Network: **$4,000** Individual/**$12,000** Family | 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?** | 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**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits. |
| **Does this plan use a network of providers?** | Yes. See www.anthem.com or call 1-877-811-3106 for a list of participating providers. | 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. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | 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 6. See your policy or plan document for additional information about **excluded services**. |

11

- **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 Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30/visit | Not covered | See separate benefit for diagnostic test services. |
| | Specialist visit | $50/visit | Not covered | See separate benefit for diagnostic test services. |
| | Other practitioner office visit | $25/visit | Not covered | Chiropractic care limited to a maximum of 20 visits per calendar year, combined with acupuncture and massage therapy. Nutritional counseling limited to 4 visits per calendar year. See separate benefit for diagnostic test services. |
| | Preventive care/screening/ immunization | No Copayment (100% covered) | Not covered | Covered preventive care services are not subject to deductible. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No deductible or coinsurance (100% covered) | Not covered | Infertility diagnostic services have a lifetime maximum of $2,000/member. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance after deductible | Not covered | Failure to obtain pre-authorization may result in reduced or no coverage. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.anthem.com | Tier 1 Generic drugs | $15/prescription (Retail); $37.50/prescription (Mail Order) | Not covered | Retail copay includes a 30-day supply; Mail Order copay includes a 90-day supply.<br><br>You may purchase a 90 day supply at the Retail pharmacy for 3 copays.<br><br>Tier 2 and Tier 3 outpatient drugs are subject to a $200 deductible per individual or a $400 deductible per family, once satisfied then services are subject to the copayment.<br><br>Certain specialty drugs must be ordered through a specialty pharmacy; see the contract plan for details.<br><br>Specialty drugs are not eligible for the 90 day Mail Order program. |
| | Tier 2 Preferred brand drugs | $40/prescription (Retail); $120/prescription (Mail Order) | Not covered | |
| | Tier 3 Non-preferred brand drugs | $60/prescription (Retail); $180/prescription (Mail Order) | Not covered | |
| | Tier 4 drugs | 30% copayment with a maximum payment of $250/prescription (Retail); $500/prescription (Mail Order) | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance after deductible | Not covered | ——————none—————— |
| | Physician/surgeon fees | 30% coinsurance after deductible | Not covered | ——————none—————— |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | $300/visit | Out-of-Network paid as In-Network | Copayment is waived if admitted. |
| | Emergency medical transportation | 30% coinsurance after deductible | Out-of-Network paid as In-Network | Out-of-Network non-emergency ambulance services are limited to a maximum benefit of $50,000 per occurrence. |
| | Urgent care | $50/visit | Out-of-Network paid as In-Network | See separate benefit for diagnostic test services. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance after deductible | Not covered | Failure to obtain pre-authorization may result in reduced or no coverage. |
| | Physician/surgeon fee | 30% coinsurance after deductible | Not covered | ——————none—————— |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $30/office visit; No deductible or coinsurance (100% covered) for outpatient facility | Not covered | In-Network: copayment applies to office visits and professional services; No coinsurance charged for facility services. |
| | Mental/Behavioral health inpatient services | 30% coinsurance after deductible | Not covered | Failure to obtain pre-authorization may result in reduced or no coverage. |
| | Substance use disorder outpatient services | $30/office visit; No deductible or coinsurance (100% covered) for outpatient facility | Not covered | In-Network: copayment applies to office visits and professional services; No coinsurance charged for facility services. |
| | Substance use disorder inpatient services | 30% coinsurance after deductible | Not covered | Failure to obtain pre-authorization may result in reduced or no coverage. |
| **If you are pregnant** | Prenatal and postnatal care | 30% coinsurance after deductible | Not covered | ——————none—————— |
| | Delivery and all inpatient services | 30% coinsurance after deductible | Not covered | Failure to obtain pre-authorization may result in reduced or no coverage. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance after deductible | Not covered | Home health care is limited to 100 visits per calendar year. |
| | Rehabilitation services | $30/visit PCP, or $50/visit Specialist | Not covered | Outpatient coverage of physical, occupational and speech therapies is limited to 20 visits each per calendar year. Inpatient benefit for therapies is limited to 30 inpatient rehab days per calendar year. Cardiac Rehabilitation is limited to 36 visits per calendar year. |
| | Habilitation services | $30/visit PCP, or $50/visit Specialist | Not covered | All rehabilitation and habilitation visits count toward your rehabilitation visit limit. |
| | Skilled nursing care | 30% coinsurance after deductible | Not covered | Failure to obtain pre-authorization may result in reduced or no coverage. Covers up to 100 days per calendar year. |
| | Durable medical equipment | 30% coinsurance after deductible | Not covered | Failure to obtain pre-authorization may result in reduced or no coverage. |
| | Hospice service | No deductible, no copayment (100% covered) | Not covered | Failure to obtain pre-authorization may result in reduced or no coverage. |
| **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
- Infertility treatment
- Long-term care
- Preauthorization – You may have to pay for all or a portion of a test, equipment, service or procedure that is not preauthorized.
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- 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 (limits apply)
- Chiropractic therapy (limits apply)
- Emergency coverage provided outside the United States. See www.BCBS.com/bluecardworldwide
- Hearing aids (limits apply)

16

## 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 your Human Resources Department. 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:

Anthem Blue Cross and Blue Shield
Appeals Department
700 Broadway, CAT CO0104-0430
Denver, CO 80273

Additionally, a consumer assistance program can help you file your appeal. Contact:

Colorado Division of Insurance
ICARE Section
1560 Broadway, Suite 850
Denver, CO 80202

17

## 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 does 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 does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

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.

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。

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.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíigo, 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.

*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** $4,660
- **Patient pays** $2,880

**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 | $1,200 |
| Copays | $0 |
| Coinsurance | $1,680 |
| Limits or exclusions | $0 |
| **Total** | **$2,880** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,510
- **Patient pays** $1,890

**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 | $1,200 |
| Copays | $600 |
| Coinsurance | $90 |
| Limits or exclusions | $0 |
| **Total** | **$1,890** |

# 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 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**, **copayments**, 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.

**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 1-877-811-3106.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For In-Network:<br>**$1,500** Individual/**$4,500** Family<br>For Out-of-Network:<br>**$3,000** Individual/**$9,000** Family<br>Deductible does not apply to preventative care, prescription drugs or copayments.<br>In-Network and Out-of-Network Deductibles are separate and do not count towards each other. | You must pay all the 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 2 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 must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. For In-Network:<br>**$3,500** Individual/**$8,500** Family<br>For Out-of-Network:<br>**$7,000** Individual/**$17,000** Family<br>In-Network and Out-of-Network Out-of-Pocket are separate and do not count towards each other. | 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?** | 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**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits. |

| | | |
|---|---|---|
| **Does this plan use a network of providers?** | Yes. See www.anthem.com or call 1-877-811-3106 for a list of participating providers. | 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 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | 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 10% would be $100. 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.

22

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-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/visit plus 10% coinsurance after deductible for all other services | 30% coinsurance after deductible | In-Network: copayment applies to office visits; coinsurance charged for any services not billed as an office visit. |
| | Specialist visit | $50/visit plus 10% coinsurance after deductible for all other services | 30% coinsurance after deductible | In-Network: copayment applies to office visits; coinsurance charged for any services not billed as an office visit. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Other practitioner office visit | $25/visit plus 10% coinsurance after deductible for all other services | Not covered | Chiropractic therapy, acupuncture and massage therapy limited to a combined maximum of 20 visits per calendar year. Nutritional counseling limited to a maximum of 4 visits per calendar year. In-Network: copayment applies to office visits; coinsurance charged for any services not billed as an office visit. |
| | Preventive care/screening/ immunization | No copayment (100% covered) | $50/visit; $500 copayment for covered facility services | Covered preventive care services are not subject to deductible. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% coinsurance after deductible | 30% coinsurance after deductible | Infertility diagnostic services have a lifetime maximum of $2,000/member. |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance after deductible | 30% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.anthem.com | Tier 1 Generic drugs | $15/prescription (Retail); $37.50/prescription (Mail Order) | Not covered | Retail includes a 30-day supply; Mail Order includes a 90-day supply.<br><br>You may purchase a 90 day supply at the Retail pharmacy for 3 copays.<br><br>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. |
| | Tier 2 Preferred brand drugs | $40/prescription (Retail); $120/prescription (Mail Order) | Not covered | |
| | Tier 3 Non-preferred brand drugs | $60/prescription (Retail); $180/prescription (Mail Order) | Not covered | |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Tier 4 drugs | 30% copayment with a maximum payment of $250/prescription (Retail); $500/prescription (Mail Order) | Not covered | Certain specialty drugs must be ordered through a specialty pharmacy; see the contract plan for details.<br>Specialty drugs are not eligible for the 90 day Mail Order program. |
| **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 | Out-of-Network paid as In-Network | ——————none—————— |
| | Emergency medical transportation | 10% coinsurance after deductible | Out-of-Network paid as In-Network | Out-of-Network non-emergency ambulance services are limited to a maximum benefit of $50,000 per occurrence. |
| | Urgent care | $50/visit plus 10% coinsurance after deductible for all other services | 30% coinsurance after deductible | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance after deductible | 30% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. Inpatient coverage for occupational, physical and speech therapies limited to 30 inpatient rehab days per calendar year In and Out-of-Network combined. |
| | Physician/surgeon fee | 10% coinsurance after deductible | 30% coinsurance after deductible | ——————none—————— |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $25/office visit, or you pay 10% coinsurance after deductible for outpatient facility services | 30% coinsurance after deductible | In-Network: copayment applies to office visits and professional services; coinsurance charged for facility services. |
| | Mental/Behavioral health inpatient services | 10% coinsurance after deductible | 30% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| | Substance use disorder outpatient services | $25/office visit, or you pay 10% coinsurance for outpatient facility services | 30% coinsurance after deductible | In-Network: copayment applies to office visits and professional services; coinsurance charged for facility services. |
| | Substance use disorder inpatient services | 10% coinsurance after deductible | 30% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| **If you are pregnant** | Prenatal and postnatal care | PCP: $25/pregnancy plus 10% coinsurance after deductible for all other services, or Specialist: $50/pregnancy; plus 10% coinsurance after deductible for all other services | 30% coinsurance after deductible | In-Network: copayment applies to first prenatal office visit/delivery services; coinsurance charged for any services not billed as an office visit and postnatal well-baby care. |
| | Delivery and all inpatient services | 10% coinsurance after deductible | 30% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance after dedutible | Not covered | Home health care is limited to 100 visits per calendar year. |
| | Rehabilitation services | 10% coinsurance after dedutible | 30% coinsurance after deductible | Outpatient coverage of physical, occupational and speech therapies is limited to 20 visits each per calendar year In and Out-of-Network combined. Inpatient benefit for therapies is limited to 30 inpatient rehab days per calendar year In and Out-of-Network combined. Cardiac Rehabilitation is limited to 36 visits per calendar year In and Out-of-Network combined. |
| | Habilitation services | 10% coinsurance after dedutible | 30% coinsurance after deductible | All rehabilitation and habilitation visits count toward your rehabilitation visit limit. |
| | Skilled nursing care | 10% coinsurance after dedutible | 30% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. Covers up to 100 days per calendar year In and Out-of-Network combined. |
| | Durable medical equipment | 10% coinsurance after dedutible | Not covered | Failure to obtain pre-authorization may result in reduced or no coverage. |
| | Hospice service | No deductible or coinsurance (100% covered) | 30% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| **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
- Infertility treatment
- Long-term care
- Preauthorization – You may have to pay for all or a portion of an test, equipment, service or procedure that is not preauthorized.
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- 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 (limits apply)
- Chiropractic care (limits apply)
- Emergency coverage provided outside the United States. See www.BCBS.com/bluecardworldwide
- Hearing Aids (limits apply)

27

## 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 your Human Resources Department. 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:

Anthem Blue Cross and Blue Shield
Appeals Department
700 Broadway, CAT CO0104-0430
Denver, CO 80273

Additionally, a consumer assistance program can help you file your appeal. Contact:

Colorado Division of Insurance
ICARE Section
1560 Broadway, Suite 850
Denver, CO 80202

28

## 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 does 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 does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

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.

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。

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.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíigo, 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.

*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** $5,660
- **Patient pays** $1,880

**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 | $80 |
| Coinsurance | $300 |
| Limits or exclusions | $0 |
| **Total** | **$1,880** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,480
- **Patient pays** $1,920

**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 | $1,300 |
| Copays | $620 |
| Coinsurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$1,920** |

# 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 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**, **copayments**, 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.

**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 1-877-811-3106.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For In-Network:<br>**$3,000** Individual/**$9,000** Family<br>For Out-of-Network:<br>**$6,000** Individual/**$18,000** Family<br>Deductible does not apply to preventive care, prescription drugs or copayments.<br>In-Network and Out-of-Network Deductibles are separate and do not count towards each other. | You must pay all the 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 2 for how much you pay for covered services after you meet the **deductible**. The family deductible is aggregate. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. For In-Network:<br>**$6,000** Individual/**$12,700** Family<br>For Out-of-Network:<br>**$12,000** Individual/**$25,400** Family<br>In-Network and Out-of-Network Out-of-Pocket are separate and do not count towards each other. | 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. The family out-of-pocket is aggregate. |
| **What is not included in the out–of–pocket limit?** | 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**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits. |

32

| | | |
|---|---|---|
| **Does this plan use a network of providers?** | Yes. See www.anthem.com or call 1-877-811-3106 for a list of participating providers. | 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 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | 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 7. 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 Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30/visit plus 30% coinsurance after deductible for all other services | 50% coinsurance after deductible | In-Network: copayment applies to office visits; coinsurance charged for any services not billed as an office visit. |
| | Specialist visit | $60/visit plus 30% coinsurance after deductible for all other services | 50% coinsurance after deductible | In-Network: copayment applies to office visits; coinsurance charged for any services not billed as an office visit. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Other practitioner office visit | $30/visit plus 30% coinsurance after deductible for all other services | Not covered | Chiropractic care, acupuncture and massage therapy limited to a combined maximum of 20 visits per calendar year. Nutritional counseling limited to a maximum of 4 visits per calendar year. In-Network: copayment applies to office visits; coinsurance charged for any services not billed as an office visit. |
| | Preventive care/screening/ immunization | No copayment (100% covered) | $60/visit; $500 copayment for covered facility services. | Covered preventive care services are not subject to deductible. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance after deductible | 50% coinsurance after deductible | Infertility diagnostic services have a lifetime maximum of $2,000/member. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance after deductible | 50% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.anthem.com | Tier 1 Generic drugs | $15/prescription (Retail); $37.50/prescription (Mail Order) | Not covered | Retail copay includes a 30-day supply; Mail Order copay includes a 90-day supply.<br><br>You may purchase a 90 day supply at the Retail pharmacy for 3 copays. |
| | Tier 2 Preferred brand drugs | $40/prescription (Retail); $120/prescription (Mail Order) | Not covered | |
| | Tier 3 Non-preferred brand drugs | $60/prescription (Retail); $180/prescription (Mail Order) | Not covered | |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Tier 4 drugs | 30% copayment with a maximum payment of $250/prescription (Retail); $500/prescription (Mail Order) | Not covered | Certain specialty drugs must be ordered through a specialty pharmacy; see the contract plan for details.<br>Specialty drugs are not eligible for the 90 day Mail Order program. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance after deductible | 50% coinsurance after deductible | ——————none—————— |
| | Physician/surgeon fees | 30% coinsurance after deductible | 50% coinsurance after deductible | ——————none—————— |
| **If you need immediate medical attention** | Emergency room services | 30% coinsurance after deductible | Out-of-Network paid as In-Network | ——————none—————— |
| | Emergency medical transportation | 30% coinsurance after deductible | Out-of-Network paid as In-Network | Out-of-Network non-emergency ambulance services are limited to a maximum benefit of $50,000 per occurrence. |
| | Urgent care | $60/visit plus 30% coinsurance after deductible for all other services | 50% coinsurance after deductible | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance after deductible | 50% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. Inpatient coverage for occupational, physical and speech therapies limited to 30 inpatient rehab days per calendar year In and Out-of-Network combined. |
| | Physician/surgeon fee | 30% coinsurance after deductible | 50% coinsurance after deductible | ——————none—————— |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $30/office visit, or 30% coinsurance after deductible for facility services | 50% coinsurance after deductible | In-Network: copayment applies to office visits and professional services; coinsurance charged for facility services. |
| | Mental/Behavioral health inpatient services | 30% coinsurance after deductible | 50% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| | Substance use disorder outpatient services | $30/office visit, or 30% coinsurance after deductible for facility services | 50% coinsurance after deductible | In-Network: copayment applies to office visits and professional services; coinsurance charged for facility services. |
| | Substance use disorder inpatient services | 30% coinsurance after deductible | 50% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| **If you are pregnant** | Prenatal and postnatal care | PCP: $30/pregnancy plus 30% coinsurance after deductible for all other services; or Specialist: $60/ pregnancy plus 30% coinsurance after deductible for all other services | 50% coinsurance after deductible | In-Network: copayment applies to first prenatal office visit/delivery from the Doctor; coinsurance charged for any services not billed as an office visit and postnatal well-baby care. |
| | Delivery and all inpatient services | 30% coinsurance after deductible | 50% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance after deductible | Not covered | Home health care is limited to 100 visits per calendar year. |
| | Rehabilitation services | 30% coinsurance after deductible | 50% coinsurance after deductible | Outpatient coverage of physical, occupational and speech therapies is limited to 20 visits each per calendar year In and Out-of-Network combined. Inpatient benefit for therapies is limited to 30 inpatient rehab days per calendar year In and Out-of-Network combined. Cardiac Rehabilitation is limited to 36 visits per calendar year In and Out-of-Network combined. |
| | Habilitation services | 30% coinsurance after deductible | 50% coinsurance after deductible | All rehabilitation and habilitation visits count toward your rehabilitation visit limit. |
| | Skilled nursing care | 30% coinsurance after deductible | 50% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. Covers up to 100 days per calendar year In and Out-of-Network combined. |
| | Durable medical equipment | 30% coinsurance after deductible | Not covered | Failure to obtain pre-authorization may result in reduced or no coverage. |
| | Hospice service | No deductible or coinsurance (100% covered) | 50% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| **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
- Infertility treatment
- Long-term care
- Preauthorization – You may have to pay for all or a portion of a test, equipment, service or procedure that is not preauthorized.
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- 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 (limits apply)
- Chiropractic care (limits apply)
- Emergency care provided outside the United States. See www.BCBS.com/bluecardworldwide
- Hearing aids (limits apply)

38

## 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 your Human Resources Department. 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:

Anthem Blue Cross and Blue Shield
Appeals Department
700 Broadway, CAT CO0104-0430
Denver, CO 80273

Additionally, a consumer assistance program can help you file your appeal. Contact:

Colorado Division of Insurance
ICARE Section
1560 Broadway, Suite 850
Denver, CO 80202

39

## 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 does 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 does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

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.

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。

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.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíigo, 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.

*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** $3,765
- **Patient pays** $3,775

**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 | $3,000 |
| Copays | $115 |
| Coinsurance | $660 |
| Limits or exclusions | $0 |
| **Total** | **$3,775** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,295
- **Patient pays** $2,105

**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 | $1,300 |
| Copays | $775 |
| Coinsurance | $30 |
| Limits or exclusions | $0 |
| **Total** | **$2,105** |

# 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 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**, **copayments**, 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.

**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 1-877-811-3106.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For In-Network:<br>**$2,000** Individual/**$6,000** Family<br>For Out-of-Network:<br>**$4,000** Individual/**$12,000** Family<br>Deductible does not apply to preventative care, prescription drugs or copayments.<br>In-Network and Out-of-Network Deductibles are separate and do not count towards each other. | You must pay all the 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 2 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 $200 deductible per individual or a $400 deductible per family for outpatient Tier 2 and Tier 3 prescription drugs. | 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. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. For In-Network:<br>**$4,000** Individual/**$10,000** Family<br>For Out-of-Network:<br>**$8,000** Individual/**$20,000** Family<br>In-Network and Out-of-Network Out-of-Pocket are separate and do not count towards each other. | 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?** | 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**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits. |



**Questions:** Call **1-877-811-3106** 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.anthem.com** or call **1-877-811-3106** to request a copy.

| | | |
|---|---|---|
| **Does this plan use a network of providers?** | Yes. See www.anthem.com or call 1-877-811-3106 for a list of participating providers. | 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 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | 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 8. 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 a Designated In-Network Provider | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $15/visit | $50/visit | 50% coinsurance after deductible | In-Network: copayment applies to office visits; 20% coinsurance after deductible charged for all non-laboratory or non-x-ray services. See separate benefit for diagnostic test services.<br>In-Network: Member Cost Shares may be higher when using a provider that is not a Desiganted Blue Priority Provider. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Designated In-Network Provider | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| | Specialist visit | $30/visit | $100/ visit | 50% coinsurance after deductible | In-Network: copayment applies to office visits; 20% coinsurance after deductible charged for all non-laboratory or non-x-ray services. See separate benefit for diagnostic test services.<br>In-Network: Member Cost Shares may be higher when using a provider that is not a Desiganted Blue Priority Provider. |
| | Other practitioner office visit | $25/visit | $25/visit | Not covered | In-Network: chiropractic therapy, acupuncture and massage therapy limited to a combined maximum of 20 visits per calendar year.<br>Nutritional counseling is limited to 4 visits per calendar year.<br>In-Network: copayment applies to office visits; 20% coinsurance after deductible charged for all non-laboratory or non-x-ray services. See separate benefit for diagnostic test services. |
| | Preventive care/ screening/ immunization | No copayment (100% covered) | $50/visit | $80/visit;<br>$500 copayment for covered facility services | Covered preventive care services are not subject to deductible.<br>In-Network: Member Cost Shares may be higher when using a provider that is not a Desiganted Blue Priority Provider. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Designated In-Network Provider | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you have a test** | Diagnostic test (x-ray, blood work) | Office Lab – No copayment (100% covered); Office X-Ray – $30/visit; Hospital Lab/X-Ray – 20% coinsurance after deductible | Office Lab – No copayment (100% covered); Office X-Ray – $30/visit; Hospital Lab/X-Ray – 20% coinsurance after deductible | 50% coinsurance after deductible | Infertility diagnostic services have a lifetime maximum of $2,000/member. |
| | Imaging (CT/PET scans, MRIs) | Office Imaging – $150/test; Hospital Imaging – 20% coinsurance after deductible | Office Imaging – $150/test; Hospital Imaging – 20% coinsurance after deductible | 50% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.anthem.com | Tier 1 Generic drugs | $15/prescription (Retail); $37.50/prescription (Mail Order) | $15/prescription (Retail); $37.50/prescription (Mail Order) | Not covered | Retail copay includes a 30-day supply; Mail Order copay includes a 90-day supply.<br><br>You may purchase a 90 day supply at the Retail pharmacy for 3 copays.<br><br>Tier 2 and Tier 3 outpatient drugs are subject to a $200 deductible per individual or a $400 deductible per family, once satisfied then services are subject to the copayment. |
| | Tier 2 Preferred brand drugs | $40/prescription (Retail); $120/prescription (Mail Order) | $40/prescription (Retail); $120/prescription (Mail Order) | Not covered | |
| | Tier 3 Non-preferred brand drugs | $60/prescription (Retail); $180/prescription (Mail Order) | $60/prescription (Retail); $180/prescription (Mail Order) | Not covered | |

| Common Medical Event | Services You May Need | Your Cost If You Use a Designated In-Network Provider | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| | Tier 4 drugs | 30% copayment with a maximum payment of $250/ prescription (Retail), or $500/prescription (Mail Order) | 30% copayment with a maximum payment of $250/ prescription (Retail), or $500/prescription (Mail Order) | Not covered | Certain specialty drugs must be ordered through a specialty pharmacy; see the contract plan for details.<br><br>Specialty drugs are not eligible for the 90 day Mail Order program. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Ambulatory Surgery Center – $200/admission; Hospital – 20% coinsurance after deductible | Ambulatory Surgery Center – $200/admission; Hospital – 20% coinsurance after deductible | 50% coinsurance after deductible | ——————none—————— |
| | Physician/ surgeon fees | No copayment (100% covered) | No copayment (100% covered) | 50% coinsurance after deductible | ——————none—————— |

| Common Medical Event | Services You May Need | Your Cost If You Use a Designated In-Network Provider | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | $350/visit | $350/visit | Out-of-Network paid as In-Network | Copayment is waived if admitted. |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after deductible | Out-of-Network paid as In-Network | Out-of-Network non-emergency ambulance services are limited to a maximum benefit of $50,000 per occurrence. |
| | Urgent care | $30/visit | $30/visit | 50% coinsurance after deductible | In-Network: copayment applies to visits; 20% coinsurance after deductible charged for all non-laboratory or non-x-ray services. See separate benefit for diagnostic test services. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | 20% coinsurance after deductible | 50% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. Inpatient coverage for occupational, physical and speech therapies limited to 30 inpatient rehab days per calendar year In and Out-of-Network combined. |
| | Physician/ surgeon fee | 20% coinsurance after deductible | 20% coinsurance after deductible | 50% coinsurance after deductible | ——————none—————— |

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|---|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $15/office visit, or 20% coinsurance after deductible for outpatient facility services | $15/office visit, or 20% coinsurance after deductible for outpatient facility services | 50% coinsurance after deductible | In-Network: copayment applies to office visits and professional services; coinsurance charged for facility services. |
| | Mental/Behavioral health inpatient services | 20% coinsurance after deductible | 20% coinsurance after deductible | 50% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| | Substance use disorder outpatient services | $15/office visit, or 20% coinsurance after deductible for outpatient facility services | $15/office visit, or 20% coinsurance after deductible for outpatient facility services | 50% coinsurance after deductible | In-Network: copayment applies to office visits and professional services; coinsurance charged for facility services. |
| | Substance use disorder inpatient services | 20% coinsurance after deductible | 20% coinsurance after deductible | 50% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| **If you are pregnant** | Prenatal and postnatal care | $200/pregnancy | $400/pregnancy | 50% coinsurance after deductible | In-Network: copayment applies to prenatal care office visit/delivery from the doctor; 20% coinsurance after deductible charged for all non-laboratory or non-x-ray services. See separate benefit for diagnostic test services.<br>In-Network: Member Cost Shares may be higher when using a provider that is not a Desiganted Blue Priority Provider. |
| | Delivery and all inpatient services | 20% coinsurance after deductible | 20% coinsurance after deductible | 50% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Designated In-Network Provider | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance after deductible | 20% coinsurance after deductible | Not covered | Home health care is limited to 100 visits per calendar year. |
| | Rehabilitation services | $15/visit | $15/visit | 50% coinsurance after deductible | Outpatient coverage of physical, occupational and speech therapies is limited to 20 visits each per calendar year In and Out-of-Network combined. Inpatient benefit for therapies is limited to 30 inpatient rehab days per calendar year In and Out-of-Network combined. Cardiac Rehabilitation is limited to 36 visits per calendar year In and Out-of-Network combined. In-Network: copayment applies to visits; 20% coinsurance after deductible charged for all non-laboratory or non-x-ray services. See separate benefit for diagnostic test services. |
| | Habilitation services | $15/visit | $15/visit | 50% coinsurance after deductible | All rehabilitation and habilitation visits count toward your rehabilitation visit limit. |
| | Skilled nursing care | 20% coinsurance after deductible | 20% coinsurance after deductible | 50% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. Covers up to 100 days per calendar year In and Out-of-Network combined. |
| | Durable medical equipment | 50% coinsurance after deductible | 50% coinsurance after deductible | Not covered | Failure to obtain pre-authorization may result in reduced or no coverage. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Designated In-Network Provider | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|---|
| | Hospice service | No deductible or coinsurance (100% covered) | No deductible or coinsurance (100% covered) | 50% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| **If your child needs dental or eye care** | Eye exam | Not covered | Not covered | Not covered | ——————none—————— |
| | Glasses | Not covered | Not covered | Not covered | ——————none—————— |
| | Dental check-up | Not covered | 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
- Infertility treatment
- Long-term care
- Preauthorization – You may have to pay for all or a portion of a test, equipment, service or procedure that is not preauthorized.
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- 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 (limits apply)
- Chiropractic care (limits apply)
- Emergency coverage provided outside the United States. See www.BCBS.com/bluecardworldwide
- Hearing aids (limits apply)

## 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 your Human Resources Department. 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:

Anthem Blue Cross and Blue Shield
Appeals Department
700 Broadway, CAT CO0104-0430
Denver, CO 80273

52

Additionally, a consumer assistance program can help you file your appeal. Contact:

Colorado Division of Insurance
ICARE Section
1560 Broadway, Suite 850
Denver, CO 80202

## 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 does 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 does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

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.

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。

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.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíigo, 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.

*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** $4,570
- **Patient pays** $2,970

**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 | $2,200 |
| Copays | $20 |
| Coinsurance | $750 |
| Limits or exclusions | $0 |
| **Total** | **$3,770** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,360
- **Patient pays** $3,040

**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 | $2,200 |
| Copays | $540 |
| Coinsurance | $300 |
| Limits or exclusions | $0 |
| **Total** | **$3,040** |

# 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 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**, **copayments**, 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.

**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 1-866-837-4596.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For In-Network:<br>**$2,500** Single/**$5,000** Non-Single<br>For Out-of-Network:<br>**$2,500** Single/**$5,000** Non-Single<br>Deductible does not apply to preventive care.<br>In-Network and Out-of-Network Deductibles are separate and do not count towards each other. | You must pay all the 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 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. For In-Network:<br>**$3,400** Single/**$6,800** Non-Single<br>For Out-of-Network:<br>**$6,800** Single/**$13,600** Non-Single<br>In-Network and Out of-Network Out-of-Pocket are separate and do not count towards each other. | 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?** | 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**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits. |

56

| | | |
|---|---|---|
| **Does this plan use a network of providers?** | Yes. See www.anthem.com or call 1-866-837-4596 for a list of participating providers. | 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 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | 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 7. 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 Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | You pay no coinsurance after deductible | 30% coinsurance after deductible | ——————none—————— |
| | Specialist visit | You pay no coinsurance after deductible | 30% coinsurance after deductible | ——————none—————— |
| | Other practitioner office visit | You pay no coinsurance after deductible | Not covered | Chiropractic therapy, acupuncture and massage therapy limited to a combined maximum of 20 visits per year. Nutritional Counseling has a maximum benefit of 4 visits per calendar year. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Preventive care/screening/ immunization | No copayment (100% covered) | $80/visit; $500 copayment for covered facility services | Covered preventive care services are not subject to deductible. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | You pay no coinsurance after deductible | 30% coinsurance after deductible | Infertility diagnostic services have a lifetime maximum of $2,000/member. |
| | Imaging (CT/PET scans, MRIs) | You pay no coinsurance after deductible | 30% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.anthem.com | Tier 1 Generic drugs | $15/prescription(Retail); $37.50/prescription (Mail Order) | 30% coinsurance after deductible (Retail Only) | Deductible must be met, then copayments apply for retail pharmacy.<br><br>Retail copay includes a 30-day supply; Mail order copay includes a 90-day supply.<br><br>You may purchase a 90 day supply at the Retail pharmacy for 3 copays.<br><br>Certain specialty drugs must be ordered through a specialty pharmacy; see the contract plan for details.<br><br>Out-of-network mail order is not covered.<br><br>Specialty drugs are not eligible for the 90 day mail order program. |
| | Tier 2 Preferred brand drugs | $40/prescription(Retail); $120/prescription (Mail Order) | 30% coinsurance after deductible (Retail Only) | |
| | Tier 3 Non-preferred brand drugs | $60/prescription(Retail); $180/prescription (Mail Order) | 30% coinsurance after deductible (Retail Only) | |
| | Tier 4 drugs | 30% copayment with a maximum copayment of $250/prescription after deductible (Retail); $500/prescription (Mail Order) | 30% coinsurance after deductible (Retail Only) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | You pay no coinsurance after deductible | 30% coinsurance after deductible | ——————none—————— |
| | Physician/surgeon fees | You pay no coinsurance after deductible | 30% coinsurance after deductible | ——————**none**—————— |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | You pay no coinsurance after deductible | Out-of-Network paid as In-Network | ——————none—————— |
| | Emergency medical transportation | You pay no coinsurance after deductible | Out-of-Network paid as In-Network | Out-of-Network non-emergency ambulance services are limited to a maximum benefit of $50,000 per occurrence. |
| | Urgent care | You pay no coinsurance after deductible | 30% coinsurance after deductible | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | You pay no coinsurance after deductible | 30% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. Inpatient coverage for occupational, physical and speech therapies limited to 30 inpatient rehab days per calendar year In and Out-of-Network combined. |
| | Physician/surgeon fee | You pay no coinsurance after deductible | 30% coinsurance after deductible | ——————none—————— |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | You pay no coinsurance after deductible | 30% coinsurance after deductible | ——————none—————— |
| | Mental/Behavioral health inpatient services | You pay no coinsurance after deductible | 30% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| | Substance use disorder outpatient services | You pay no coinsurance after deductible | 30% coinsurance after deductible | ——————none—————— |
| | Substance use disorder inpatient services | You pay no coinsurance after deductible | 30% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| **If you are pregnant** | Prenatal and postnatal care | You pay no coinsurance after deductible | 30% coinsurance after deductible | ——————none—————— |
| | Delivery and all inpatient services | You pay no coinsurance after deductible | 30% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | You pay no coinsurance after deductible | Not covered | Home health care is limited to 100 visits per calendar year. |
| | Rehabilitation services | You pay no coinsurance after deductible | 30% coinsurance after deductible | Outpatient coverage of physical, occupational and speech therapies is limited to 20 visits each per calendar year In and Out-of-Network combined. Inpatient benefit for therapies is limited to 30 inpatient rehab days per calendar year In and Out-of-Network combined. Cardiac Rehabilitation is limited to 36 visits per calendar year In and Out-of-Network combined. |
| | Habilitation services | You pay no coinsurance after deductible | 30% coinsurance after deductible | All rehabilitation and habilitation visits count toward your rehabilitation visit limit. |
| | Skilled nursing care | You pay no coinsurance after deductible | 30% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. Covers up to 100 days per calendar year In and Out-of-Network combined. |
| | Durable medical equipment | You pay no coinsurance after deductible | Not covered | Failure to obtain pre-authorization may result in reduced or no coverage. |
| | Hospice service | You pay no coinsurance after deductible | 30% coinsurance after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. |
| **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
- Infertility treatment
- Long-term care
- Preauthorization – You may have to pay for all or a portion of a test, equipment, service or procedure that is not preauthorized.
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- 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 (limits apply)
- Chiropractic therapy (limits apply)
- Emergency care coverage provided outside the United States. See www.BCBS.com/bluecardworldwide
- Hearing aids (limits apply)

61

## 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 your Human Resources Department. 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:

Anthem Blue Cross and Blue Shield
Appeals Department
700 Broadway, CAT CO0104-0430
Denver, CO 80273

Additionally, a consumer assistance program can help you file your appeal. Contact:

Colorado Division of Insurance
ICARE Section
1560 Broadway, Suite 850
Denver, CO 80202

62

## 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 does 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 does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

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.

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。

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*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** $5,010
- **Patient pays** $2,530

**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 | $2.500 |
| Copays | $30 |
| Coinsurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$2,530** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,600
- **Patient pays** $2,800

**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 | $2,500 |
| Copays | $300 |
| Coinsurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$2,800** |

# 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 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**, **copayments**, 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.

**Your Summary of Benefits**
**ERC**
**Anthem Dental Complete**

**WELCOME TO YOUR DENTAL PLAN!**
This benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your certificate of coverage.

**Dental coverage you can count on**

Your Anthem dental plan lets you visit any licensed dentist or specialist you want - with costs that are normally lower when you choose one within our large network.

**Savings beyond your dental plan benefits - you get more for your money.**
You pay our negotiated rate for covered services from in-network dentists even if you exceed your annual benefit maximum.

| YOUR DENTAL PLAN AT A GLANCE | In-Network | Out-of-Network |
|---|---|---|
| **Annual Benefit Maximum** Calendar Year | | |
| ▪ Per insured person | **$1,200** | **$1,200** |
| **D&P applies to Annual Maximum** | **Yes** | **Yes** |
| **Annual Maximum Carryover** | **No** | **No** |
| **Orthodontic Lifetime Benefit Maximum** | | |
| ▪ Per eligible insured person | **$1,000** | **$1,000** |
| **Annual Deductible (The Deductible does not apply to Orthodontic Services)** | | |
| ▪ Per insured person Calendar Year | **$0** | **$0** |
| ▪ Family maximum | **3X Individual** | **3X Individual** |
| **Deductible Waived for Diagnostic/Preventive Services** | **Yes** | **Yes** |
| **Out-of-Network Reimbursement Options:** | **90th percentile** | |

| Dental Services | In-Network Anthem Pays: | Out-of-Network Anthem Pays: | Waiting Period |
|---|---|---|---|
| **Diagnostic and Preventive Services**<br>▪ Periodic oral exam<br>▪ Teeth cleaning (prophylaxis)<br>▪ Bitewing X-rays: 1X per 12 months<br>▪ Intraoral X-rays | 100% Coinsurance | 80% Coinsurance | No Waiting Period |
| **Basic Services**<br>▪ Amalgam (silver-colored) Filling<br>▪ Front composite (tooth-colored) Filling<br>▪ Back composite Filling, Alternated to Amalgam Benefit<br>▪ Simple Extractions | 100% Coinsurance | 80% Coinsurance | No Waiting Period |
| **Endodontics**<br>▪ Root Canal | 50% Coinsurance | 50% Coinsurance | 12 Month |
| **Periodontics**<br>▪ Scaling and root planing | 50% Coinsurance | 50% Coinsurance | 12 Month |
| **Oral Surgery**<br>▪ Surgical Extractions | 50% Coinsurance | 50% Coinsurance | 12 Month |
| **Major Services**<br>▪ Crowns | 50% Coinsurance | 50% Coinsurance | 12 Month |
| **Prosthodontics**<br>▪ Dentures<br>▪ Bridges<br>▪ Dental implants Standard - Covered | 50% Coinsurance | 50% Coinsurance | 12 Month |
| **Prosthetic Repairs/Adjustments** | 50% Coinsurance | 50% Coinsurance | 12 Month |
| **Orthodontic Services**<br>·Dependent Children Only* | 50% Coinsurance | 50% Coinsurance | 12 Months |

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your certificate of coverage. In the event of a discrepancy between the information in this summary and the certificate of coverage, the certificate will prevail.

*Child orthodontic coverage begins at age eight and runs through age 18. This means that the child must have been banded between the ages of eight and 19 in order to receive coverage. If children are dependents until age 19, they can continue to receive coverage, but they must have been banded before age 19.

CO_PCLG_FI-Custom

**Emergency dental treatment for the international traveler**
As an Anthem dental member, you and your eligible, covered dependents automatically have access to the International Emergency Dental Program.**
With this program, you may receive emergency dental care from our listing of credentialed dentists while traveling or working nearly anywhere in the world.

** The International Emergency Dental Program is managed by DeCare Dental, which is an independent company offering dental-management services to Anthem Blue Cross Life and Health Insurance Company.

**Promoting healthy mouths for members who are pregnant or living with diabetes**
If you are pregnant or living with diabetes, you can sign up to receive one additional dental cleaning or periodontal maintenance procedure per year.

**Finding a dentist is easy.**
To select a dentist by name or location:
• Go to anthem.com or the website listed on the back of your ID card.
• Call the toll-free customer service number listed on the back of your ID card.

**TO CONTACT US:**

| Call | Write |
|---|---|
| Refer to the toll-free number indicated on the back of your plan ID card to speak with a U.S.-based customer service representative during normal business hours. Calling after hours? We may still be able to assist you with our interactive voice-response system. | Refer to the back of your plan ID card for the address. |

## Limitations & Exclusions

Limitations – Below is a partial listing of dental plan limitations when these services are covered under your plan. Please see your certificate of coverage for a full list.

**Diagnostic and Preventive Services**

**Oral evaluations** (exam) Limited to two per Calendar Year

**Teeth cleaning** (prophylaxis) Limited to two per Calendar Year

**Intraoral X-rays, single film** Limited to four films per 12-month period

**Complete series X-rays** (panoramic or full-mouth) Coverage Every 3 Years

**Topical fluoride application** Limited to once every 12 months for members through age 18

**Sealants** Limited to first and second molars once every 24 months per tooth for members through age 15; sealants may be covered under Diagnostic and Preventive or Basic Services.

**Basic and/or Major Services*****

**Fillings** Limited to once per surface per tooth in any 24 months

**Space Maintainers** Limited to extracted primary posterior teeth once per lifetime per tooth for members through age 16; Space Maintainers may be covered under Diagnostic and Preventive or Basic Services.

**Crowns** Limited to once per tooth in a seven-year period

**Fixed or removable prosthodontics – dentures, partials, bridges, tooth implants**

Covered once in any seven-year period; benefits are provided for the replacement of an existing bridge, denture or partial for members age 16 or older if the appliance is seven years old or older and cannot be made serviceable.

**Root canal therapy** Limited to once per lifetime per tooth; coverage is for permanent teeth only.

**Periodontal surgery** Limited to one complex service per single tooth or quadrant in any 36 months, and only if the pocket depth of the tooth is five millimeters or greater

**Periodontal scaling and root planing** Limited to once per quadrant in 36 months when the tooth pocket has a depth of four millimeters or greater

**Brush Biopsy** Not Covered

***Waiting periods** for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan.

There is a waiting period of up to 24 months for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

**ADDITIONAL LIMITATION FOR ORTHODONTIC SERVICES**

**Orthodontia Limited to one course of treatment per member per lifetime**

**Exclusions – Below is a partial listing of noncovered services under your dental plan. Please see your certificate of coverage for a full list.**

**Services provided before or after the term of this coverage**

**Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate**

**Orthodontics (unless included as part of your dental plan benefits)** Orthodontic braces, appliances and all related services

**Cosmetic dentistry** Services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

**Drugs and medications** Intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

**Extractions** - Surgical removal of third molars (wisdom teeth) that do not exhibit symptoms or impact the oral health of the member

The in-network dental providers mentioned in this communication are independently contracted providers who exercise independent professional judgment. They are not agents or employees of Anthem Blue Cross Life and Health Insurance Company.

**Choice of dentists**
While your dental plan lets you choose any dentist, you may end up paying more for a service if you visit an out-of-network dentist.

**Here's why:**

In-network dentists have agreed to payment rates for various services and cannot charge you more. On the other hand, out-of-network dentists don't have a contract with us and are able to bill you for the difference between the total amount we allow to be paid for a service – called the "maximum allowed amount" – and the amount they usually charge for a service. When they bill you for this difference, it's called "balance billing."

**How Anthem dental decides on maximum allowed amounts**
For services from an out-of-network dentist, the maximum allowed amount is determined in one of the following ways:

- Out-of-network dental fee schedule/rate developed by Anthem, which may be updated based on such things as reimbursement amounts accepted by dentists contracted with our dental plans, or other industry cost and usage data
- Information provided by a third-party vendor that shows comparable costs for dental services
- In-network dentist fee schedule

**Here's an example of higher costs for out-of-network dental services**

This is an example only. Your experience may be different, depending on your insurance plan, the services you receive and the dentist who provides the services.

Ted gets a crown from an out-of-network dentist, who charges $1,200 for the service and bills Anthem for that amount.
Anthem's maximum allowed amount for this dental service is $800. That means there will be a $400 difference, which the dentist can "balance bill" Ted.

Since Ted will also need to pay $400 coinsurance, the total he'll pay the out-of-network dentist is $800.
Here's the math:

- Dentist's charge: $1,200
- Anthem's maximum allowed amount: $800
- Anthem pays 50%: $400
- Ted pays 50% (coinsurance): $400
- Balance Ted owes the provider: $1,200 - $800 = $400
- Ted's total cost: $400 coinsurance + $400 provider balance = $800

In the example, if Ted had gone to an in-network dentist, his cost would be only $400 for the coinsurance because he would not have been "balance billed" the $400 difference.

**WELCOME TO BLUE VIEW VISION!**

Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!

Anthem BlueCross BlueShield

# Blue View Vision℠ BVV B10/10

**Your Blue View Vision network**

Anthem Blue Cross and Blue Shield vision members have access to one of the nation's largest vision networks. Blue View Vision is the only vision plan that gives members the ability to use their in-network benefits at 1-800 CONTACTS, or choose a private practice eye doctor, or go in store to LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical and most Pearle Vision® locations.

**Out-of-network:** If you choose to, you may receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement of your out-of-network allowance. In-network benefits and discounts will not apply.

## YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

| VISION PLAN BENEFITS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Routine eye exam** once every 12 months | $10 copay | $35 allowance |
| **Eyeglass frames**<br>Once every 24 months you may select an eyeglass frame and receive an allowance toward the purchase price | $130 allowance, then 20% off any remaining balance | $45 allowance |
| **Eyeglass lenses** *(Standard)*<br>Once every 12 months you may receive any one of the following lens options: | | |
| • Standard plastic single vision lenses *(1 pair)* | $10 copay | $25 allowance |
| • Standard plastic bifocal lenses *(1 pair)* | $10 copay | $40 allowance |
| • Standard plastic trifocal lenses *(1 pair)* | $10 copay | $55 allowance |
| **Eyeglass lens enhancements**<br>When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost. | | |
| • Transitions Lenses (for a child under age 19) | $0 copay | No allowance on lens enhancements when obtained out-of-network |
| • Standard Polycarbonate (for a child under age 19) | $0 copay | |
| • Factory Scratch Coating | $0 copay | |
| **Contact lenses** – once every 12 months | | |
| Prefer contact lenses over glasses? You may choose contact lenses instead of eyeglass lenses and receive an allowance toward the cost of a supply of contact lenses. | | |
| • Elective Conventional Lenses; or | $130 allowance, then 15% off any remaining balance | $80 allowance |
| • Elective Disposable Lenses; or | $130 allowance *(no additional discount)* | $80 allowance |
| • Non-Elective Contact Lenses | Covered in full | $210 allowance |

*Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.*

**BLUE VIEW VISION MEMBER EXCLUSIVE!**

**You may use your in-network benefit to order your contact lenses from 1-800 CONTACTS®**
**1-800 CONTACTS offers a huge in-stock inventory, unbeatable prices, outstanding customer service and free shipping.**
**Just call 1-800 CONTACTS or go to 1800contacts.com for fast and easy ordering of your contact lenses.**

**EXCLUSIONS & LIMITATIONS (not a comprehensive list)**

**Combined Offers.** Not to be combined with any offer, coupon, or in-store advertisement.
**Excess Amounts.** Amounts in excess of covered vision expense.
**Sunglasses.** Sunglasses and accompanying frames.
**Safety Glasses.** Safety glasses and accompanying frames.
**Not Specifically Listed.** Services not specifically listed in this plan as covered services.
**Lost or Broken Lenses or Frames.** Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
**Non-Prescription Lenses.** Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
**Orthoptics.** Orthoptics or vision training and any associated supplemental testing.

| OPTIONAL SAVINGS AVAILABLE FROM IN-NETWORK PROVIDERS ONLY | | In-network Member Cost (after any applicable copay) |
|---|---|---|
| **Retinal Imaging** - at member's option can be performed at time of eye exam | | Not more than $39 |
| **Eyeglass lens upgrades**<br>When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies. | • Transitions lenses (Adults)<br>• Standard Polycarbonate (Adults)<br>• Tint (Solid and Gradient)<br>• UV Coating<br>• Progressive Lenses[1]<br>  • Standard<br>  • Premium Tier 1<br>  • Premium Tier 2<br>  • Premium Tier 3<br>• Anti-Reflective Coating[2]<br>  • Standard<br>  • Premium Tier 1<br>  • Premium Tier 2<br>• Other Add-ons and Services | $75<br>$40<br>$15<br>$15<br><br>$65<br>$85<br>$95<br>$110<br><br>$45<br>$57<br>$68<br>20% off retail price |
| **Additional Pairs of Eyeglasses**<br>Anytime from any Blue View Vision network provider | • Complete Pair<br>• Eyeglass materials purchased separately | 40% off retail price<br>20% off retail price |
| **Eyewear Accessories** | • Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc. | 20% off retail price |
| **Contact lens fit and follow-up**<br>A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed. | • Standard contact lens fitting[3]<br>• Premium contact lens fitting[4] | Up to $55<br>10% off retail price |
| **Conventional Contact Lenses** | • Discount applies to materials only | 15% off retail price |
| **SOME OF THE ADDITIONAL SAVINGS AVAILBLE THROUGH OUR SPECIAL OFFERS PROGRAM** | | |
| 1800 CONTACTS<br>After your benefits for the coverage period have been used, you can save on contact lenses with this offer.[5] | • For this and other great offers, login to member services, select discounts, then Vision, Hearing & Dental | Save $20 on orders of $100 or more and get free shipping |
| **Laser vision correction surgery**<br>LASIK refractive surgery. | • For this offer and more like it, login to member services, select discounts, then Vision, Hearing & Dental | Discount per eye |

[1] Please ask your provider for his/her recommendation as well as the progressive brands by tier.

[2] Please ask your provider for his/her recommendation as well as the coating brands by tier.

[3] A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

[5] Discount cannot be used in conjunction with your covered benefits.

**OUT-OF-NETWORK**

If you choose an out-of-network provider, please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. When visiting an out-of-network provider, discounts do not apply and you are responsible for payment of services and/or eyewear materials at the time of service.

**To Fax:** 866-293-7373
**To Email:** oonclaims@eyewearspecialoffers.com
**To Mail:** Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

**Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. If you have questions about your benefits or need help finding a provider, visit anthem.com or call us at 1-866-723-0515.**

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. Discounts referenced are not covered benefits under this vision plan and therefore are not included in the member's policy. Laws in some states may prohibit network providers from discounting products and services that are not covered benefits under the plan. Frame discounts may not apply to some frames where the manufacturer has imposed a no discount policy on sales at retail and independent provider locations. Discounts are subject to change without notice. This benefit overview is only one piece of your entire enrollment package.

**Welcome to Anthem Life!** Good news—life insurance coverage is easy to understand. This benefit summary gives a basic outline of life insurance coverage including benefits that can be used now, and much more!

Anthem Life

# Your Optional Life Insurance Benefits

## Employers Resource of Colorado

Benefits effective 01/01/2013

Feel confident in knowing that your family is protected with Anthem Life's Optional Group Term Life Insurance. Please review your benefit certificate for specific plan details, eligibility definitions, limitations and exclusions.

**Optional group term life insurance benefit amount**

You may purchase coverage in an amount from $10,000 to the lesser of 5x earnings or $500,000 in increments of $10,000. Your family or beneficiary will get this additional benefit amount if you pass away.

If you choose an optional life benefit amount of more than $140,000, you will need to have a personal health statement approved by Anthem Life. Your optional life benefit amount will be limited to $140,000 if it's not approved by Anthem Life.

**Optional accidental death and dismemberment insurance benefit amount:** same as optional life election

Optional accidental Death and Dismemberment Insurance pays a benefit to your beneficiary if your death is caused by an accident. You may also get part of this benefit if an accident results in the loss of sight, a limb, certain fingers or toes, speech, hearing or certain types of paralysis (not able to move part of your body).

**Optional life coverage for your family**

You may also choose additional life coverage for your spouse and your children:

You may purchase coverage for your spouse in increments of $5,000 in an amount from $5,000 to $500,000, not to exceed 100% of employee's benefit.

You may purchase coverage for your children aged 15 days to 26 years in increments of $2,000 in an amount from $2,000 to $10,000.

If you choose optional life coverage for your Spouse of more than $25,000 your Spouse will need to have a personal health statement approved by Anthem Life. Your Spouse's optional life benefit amount will be limited to $25,000 if it's not approved by Anthem Life.

**Benefits after age 65**

You will still have benefits after age 65, though they will reduce as follows:

35% reduction at age 70; 50% at age 75

*All benefits end at retirement.*

**Living Benefit (accelerated death benefit)**

You can ask for up to 75% of your optional life benefits to be paid while you are living, if you are terminally ill with less than 12 months to live. If you take a Living Benefit payment, the amount your beneficiary gets after your death will be reduced by the amount you were paid.

**Waiver of premium**

We may continue your life insurance coverage until you turn 65 if you become totally disabled and not able to work prior to age 60. You will not pay premiums after the first six months after we approve your waiver of premium claim.

**Portability of optional life insurance**

If you leave employment for reasons other than retirement or disability, this feature allows you to take your optional life insurance coverage with you by paying the required premiums. Plus, the rates are typically lower than an individual policy.

**Conversion**

If you leave your job – for any reason – you may be able to change your group life coverage to an individual policy. You must apply for coverage and pay the first month's premium for the individual policy within 31 days of the last day you were employed.

**Additional optional accidental death and dismemberment insurance benefits**

Your optional AD&D coverage also includes extra benefits that also pay for certain losses: *Seat Belt Benefit* if you die in an auto accident while wearing a seatbelt and *Air Bag Benefit* if you die in an auto accident while wearing a seatbelt in a car that has an airbag; *Child Education Benefit* helps pay your eligible child's college costs if you die in an accident; *Repatriation Benefit*, helps pay costs to prepare and transport your body if you die in an accident more than 75 miles from home; *Common Carrier Benefit* if you die in a public transportation accident; *Coma Benefit* if you are in a coma due to an accident.

**Resource Advisor**

This support program comes with your life coverage to give you and your family private access to work/life resources, at no additional cost to you, including: counseling sessions for qualifying events; identity theft victim recovery services; legal and financial consultations; toll-free, 24/7 phone consultations and referrals from anywhere in the United States; and unlimited access to Resource Advisor online resources at www.resourceadvisor.anthem.com, program name "anthemresourceadvisor". You can also access Resource Advisor benefits by calling (888) 209-7840.

**Travel assistance**

This program comes with your life coverage to give you access to emergency medical help, travel services and useful tips for your trip if you travel more than 100 miles from home – all at no additional cost to you. To access benefits, visit www.europassistance-usa.com. The username is AnthemLife, the password is 75293. You can also access Travel assistance benefits by calling: US and Canada (866) 295-4890, other locations (call collect) (202) 296-7482.

**SpecialOffers@Anthem[sm]**

This program gives you and your family money saving discounts on products and services that promote better health and well-being. To find out more about SpecialOffers@Anthem[sm] discounts and benefits, go to anthem.com/specialoffers.

**Beneficiary support programs**

If you should pass away, we're here to help your beneficiary (the person who gets your life insurance benefit):

- Beneficiaries continue to have access to Resource Advisor services, including all the features described above, plus they get three face-to-face visits with a counselor in the first six months after their loss.
- Beneficiary Companion services help them close accounts and settle important estate matters with one phone call. That way, they can focus on healing.
- Beneficiaries can order copies of *The Healing Book – Facing the Death – and Celebrating the Life – of Someone You Love* for children affected by the loss. This book can really help children at a time when they need it most – and there's no charge for it.
- Your beneficiary can choose to have your life insurance benefits paid through our Access Advantage account. That way the funds can be used right away or when they are needed. Access Advantage accounts earn interest, so important investment decisions can be made later, at a less stressful time.

# Cost for optional life benefits

| Employee optional group term life and optional AD&D rates | | | |
|---|---|---|---|
| **AGE** | **Monthly Rate per $1,000 of coverage** | **AGE** | **Monthly Rate per $1,000 of coverage** |
| **<25** | 0.07 | **50-54** | 0.24 |
| **25-29** | 0.07 | **55-59** | 0.36 |
| **30-34** | 0.07 | **60-64** | 0.51 |
| **35-39** | 0.08 | **65-69** | 0.87 |
| **40-44** | 0.12 | **70-74** | 1.89 |
| **45-49** | 0.16 | **75+** | 3.05 |
| **Spouse optional group term life rates – BASED ON EMPLOYEE'S AGE** | | | |
| **AGE** | **Monthly Rate per $1,000 of coverage** | **AGE** | **Monthly Rate per $1,000 of coverage** |
| **<25** | 0.04 | **50-54** | 0.21 |
| **25-29** | 0.04 | **55-59** | 0.33 |
| **30-34** | 0.04 | **60-64** | 0.48 |
| **35-39** | 0.05 | **65-69** | 0.84 |
| **40-44** | 0.09 | **70-74** | 1.86 |
| **45-49** | 0.13 | **75+** | 3.02 |
| **Child optional group term life rates – Monthly Rate per $1,000 of coverage:** 0.21 | | | |

**How to calculate your premium**

In the above rate chart, you will see monthly rates per $1,000 of coverage. Find your age band and note the rate, then complete the information below to find your monthly, weekly, bi-weekly or semi-monthly premium.

**Employee Age: _____**

**Employee Monthly Rate per $1,000 of Coverage: _____** (A)

**Spouse Monthly Rate per $1,000 of Coverage: _____** (B)

**Child Monthly Rate per $1,000 of Coverage: _____** (C)

_____ of coverage X _____ (A) / 1,000 = _____ **Monthly Premium for Employee (D)**

_____ of coverage X _____ (B) / 1,000 = _____ **Monthly Premium for Spouse (E)**

_____ of coverage X _____ (C) / 1,000 = _____ **Monthly Premium for Child (F)**

**TOTAL MONTHLY PREMIUM (D) + (E) + (F) = _____ (G)**


AL-2128 (5/12)

# Getting started with Home Delivery Pharmacy

**If you take prescribed medicine on a regular basis, you can get up to a 90-day supply mailed right to your door.* Here's how to start:**

## Step one

**Create your account and print your order form**

There are two ways to do this:

- Log on to your health plan's website.
  - Register at your health plan website if you haven't done so.
  - Click **Prescription Benefits** in the *Useful Tools* box.
  - Click **Start a New Prescription**.

This takes you to the Express Scripts website. You can find out how to:

- Print an order form to mail in with your prescription.
- Print a fax form to take to your doctor to fax in your prescription.
- See how much your medicine will cost.

## Step two

**See your doctor for a prescription for a 90-day supply of your medicine**

You'll need a 90-day supply prescription for your first Home Delivery Pharmacy order. But you should also ask your doctor to write you another prescription for a 30-day supply. This is so you can get the 30-day supply filled at your local pharmacy while your first Home Delivery order is being processed.

- Your doctor can give you a prescription to mail in with your order form.
- Or, the doctor can fill out the physician fax form and fax it to the phone number on the form.

If your doctor prescribes a brand-name drug, your plan design may require the Home Delivery Pharmacy to substitute the generic version instead.

## Step three

**Paying for your prescription**

You can pay by e-check, check, money order or credit card. Make checks and money orders payable to Express Scripts, and write your member ID number on the front. You can enroll in e-check payments, have credit cards on file through the website or call the number on your member ID card.

## Step four

**Send us your prescription**

You can send us your prescription in two ways:

- **Mail:** Fill out the order form and mail it with the prescription and payment (if you're using a check/money order) to the address listed on the form. Please fill out payment information on the form if you're not using a check/money order.
- **Fax**: Your doctor can complete the physician fax form and fax it to the phone number on the form.

All prescriptions and refills, including those sent in by your doctor, are processed as soon as they are received. Please don't send in your prescription unless you are ready to have it filled.

## Important to know

Your medicine will be sent to your home within two weeks from the time the Home Delivery Pharmacy gets your order. If you need your medicine sooner, call the number on your ID card to ask for your order to be sent overnight. Please allow three to five days for processing plus the shipping time. You will be charged an additional fee. Your order will be sent through the post office, UPS or FedEx. Please note, with some medicines, you may have to sign to accept delivery.

## Need help getting started?

Call the phone number on your ID card. You will be transferred to Express Scripts. They can help you get started.

*Based on drug benefit plan design.





27832MUMENABS 1/14

# Take care of yourself. Use your preventive care benefits.

Anthem BlueCross BlueShield

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans offer the services listed in this preventive care flier at no cost to you.[1] When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

## Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses. For example, say your doctor suggests you have a colonoscopy because of your age when you have no symptoms. That's preventive care. On the other hand, say you have symptoms and your doctor suggests a colonoscopy to see what's causing them. That's diagnostic care.

## Child preventive care

### Preventive physical exams

### Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Vision screening[2] when done as part of a preventive care visit

### Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A and Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chickenpox)

## Women's preventive care

- Well-woman visits
- Breast cancer, including exam, mammogram, and, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met[6]
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling (female)[3,4]
- Contraceptive (birth control) counseling
- FDA-approved contraceptive medical services provided by a doctor, including sterilization
- Counseling related to chemoprevention for women with a high risk of breast cancer
- Counseling related to genetic testing for women with a family history of ovarian or breast cancer
- HPV screening[4]
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings: includes, but is not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV[4]
- Pelvic exam and Pap test, including screening for cervical cancer

The preventive care services listed are recommendations as a result of the Affordable Care Act (ACA, or health care reform law). The services listed may not be right for every person. Ask your doctor what's right for you, based on your age and health condition(s).

*This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the provisions of the group policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions and Limitations.*

## Adult preventive care

### Preventive physical exams

### Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and CT colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening
- Eye chart test for vision[2]
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- Obesity: related screening and counseling
- Prostate cancer, including digital rectal exam and PSA test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Violence, interpersonal and domestic: related screening and counseling

### Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- Measles, mumps and rubella (MMR)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)
- Zoster (shingles)

1 The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your certificate of coverage or call the Customer Care number on your ID card.

2 Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

3 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.

4 This benefit also applies to those younger than 19.

5 A cost share may apply for other prescription contraceptives, based on your drug benefits.

6 Check your medical policy for details.

# How we protect our members

As a member, you have the right to expect the privacy of your personal health information to be protected, consistent with state and federal laws and our policies. And you also have certain rights and responsibilities when receiving your health care.

To learn more about how we protect your privacy, your rights and responsibilities when receiving health care and your rights under the Women's Health and Cancer Rights Act, go to www.anthem.com/memberrights.

### How we help manage your care

To decide if we'll cover a treatment, procedure or hospital stay, we use a process called Utilization Management (UM). UM is a program that lets us make sure you're getting the right care at the right time. Licensed health care professionals review information your doctor has sent us to see if the requested care is medically needed. These reviews can be done before, during or after a member's treatment. UM also helps us decide if the services will be covered by your health plan.

We also use case managers. They're licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

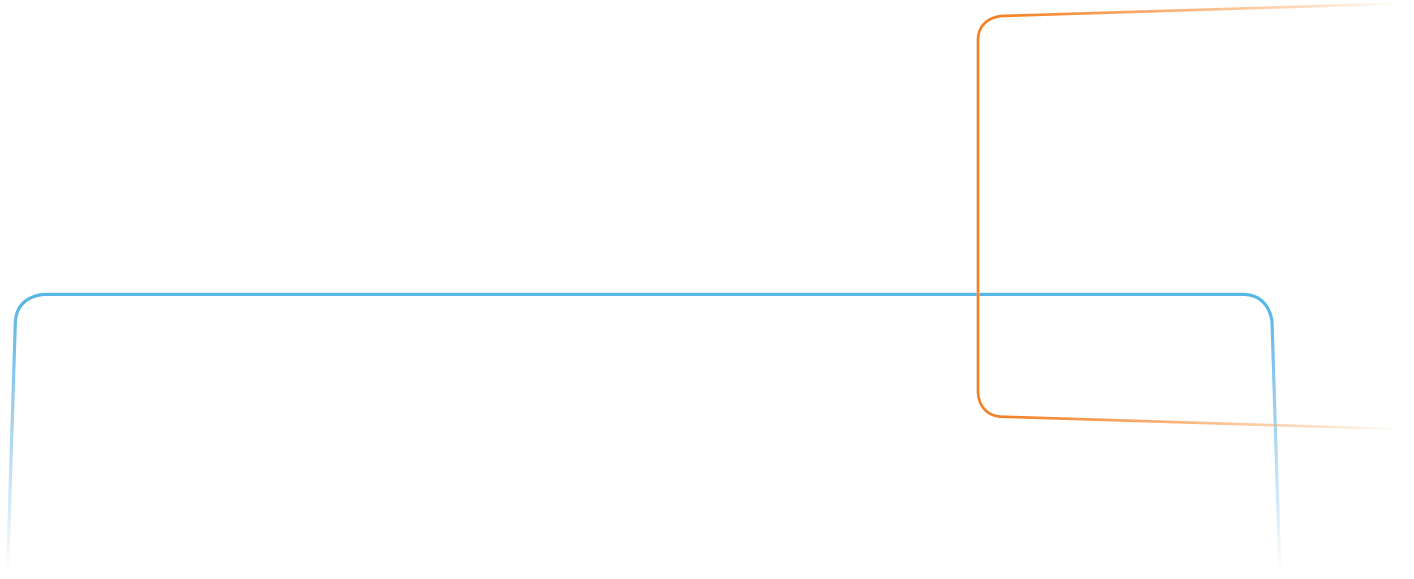
To learn more about how we help manage your care, visit www.anthem.com/memberrights.

## Special Enrollment Rights

There are certain situations when you can enroll in a plan outside the open enrollment period. Open enrollment usually happens only once a year. That's the time you can enroll in a plan or make changes to it. If you choose not to enroll during open enrollment, there are special cases when you're allowed to enroll yourself and your dependents. Special enrollment is allowed:

- ***If you had another health plan that was canceled.*** If you, your dependents or your spouse are no longer eligible for other coverage (or if the employer stops contributing to your health plan), you may be able to enroll with us. You must enroll within 31 days after the other coverage ends (or after the employer stops paying for it).
  - For example: You and your family are enrolled through your spouse's coverage at work. Your spouse's employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents, may be able to enroll in a plan.
- ***If you have a new dependent.*** This could mean a life event like marriage, birth, adoption or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you got married, your new spouse and any new children may be able to enroll in a plan.
- ***If your eligibility for Medicaid or SCHIP changes.*** You have a special period of 60 days to enroll after:
  - You (or your eligible dependents) lose Medicaid or CHIP coverage because you're no longer eligible.
  - You (or eligible dependents) become eligible to get help from Medicaid or SCHIP for paying part of the cost.

# Notes



# Carry an ID card that means something. **Enroll now.**