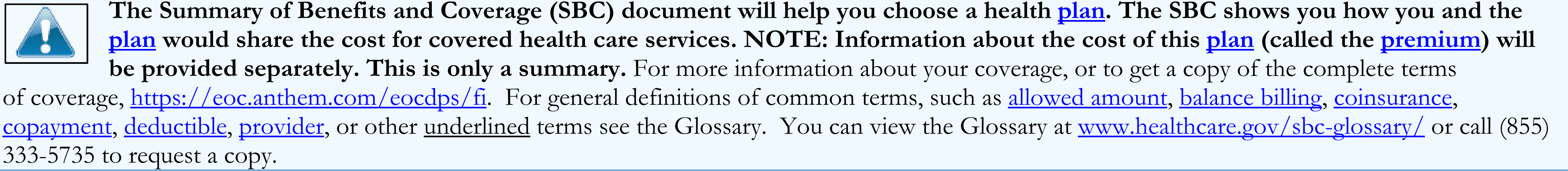
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 01/01/2019– 12/31/2019**

Anthem Blue Cross and Blue Shield **Coverage for:** Individual + Family | **Plan Type: PPO**

D49 WellChoice BlueClassic



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://eoc.anthem.com/eocdps/fi. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (855) 333-5735 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500**/single or **$3,000**/family for Tier 1 In-Network Providers. **$3,500**/single or **$7,000**/family for Tier 2 In-Network Providers. **$7,900**/single or **$15,800**/family for Non-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. Deductible applies before coinsurance unless specifically indicated otherwise. The Tier 1 In-Network Deductible does not apply toward the Tier 2 In-Network Deductible or the Out-of-Network Deductible. The Out-of-Network Deductible does not apply toward the Tier 1 or Tier 2 In-Network Deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, Primary Care visit, and Specialist visit for In-Network Providers.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$3,500**/single or **$7,000**/family for Tier 1 In-Network Providers. **$4,400**/single or **$8,800**/family for Tier 2 In-Network Providers. **$15,800**/single or **$31,600**/family for Non-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. The Tier 1 In-Network out-of-pocket limit does not apply toward the Tier 2 In-Network out-of-pocket limit or the Out-of-Network out-of-pocket limit. The Out-of-Network out-of-pocket limit does not apply toward the Tier 1 or Tier 2 In-Network out-of-pocket limit.
What is not included in the out-of-pocket	Pre-Authorization Penalties, Premiums, balance-billing	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

limit?	charges, and health care this plan doesn't cover.	
Will you pay less if you use a network provider?	Yes, WellChoice PPO. See www.anthem.com or call (855) 333-5735 for a list of network providers.	You pay the least if you use a provider in Tier 1 In-Network. You pay more if you use a provider in Tier 2 In-Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies unless stated otherwise.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit deductible does not apply	$50/visit deductible does not apply	50% coinsurance	--------none--------
	Specialist visit	$50/visit deductible does not apply	$100/visit deductible does not apply	50% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will cover.
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office No charge X-Ray – Office 20% coinsurance	Lab – Office No charge X-Ray – Office 40% coinsurance	Lab – Office 50% coinsurance X-Ray – Office 50% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	50% coinsurance	--------none--------
Prescription Drugs Covered through Express Scripts					

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/fi.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	50% coinsurance	--------none--------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	20% coinsurance	Covered as In-Network	Covered as In-Network	Tier 2 and Tier 3 covered as Tier 1, members cost share applies to Tier 1 out of pocket only.
	Emergency medical transportation	20% coinsurance	Covered as In-Network	Covered as In-Network	Tier 2 and Tier 3 covered as Tier 1, members cost share applies to Tier 1 out of pocket only.
	Urgent care	$50/visit deductible does not apply	$100/visit deductible does not apply	Covered as In-Network Tier 2	Copay waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	50% coinsurance	30 day limit/benefit period for Inpatient Rehabilitation.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	50% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit $25/visit deductible does not apply Other Outpatient 20% coinsurance	Office Visit $50/visit deductible does not apply Other Outpatient 40% coinsurance	Office Visit 50% coinsurance Other Outpatient 50% coinsurance	--------none--------
	Inpatient services	20% coinsurance	40% coinsurance	50% coinsurance	--------none--------
If you are pregnant	Office visits	$50/pregnancy deductible does not apply	$100/pregnancy deductible does not apply	50% coinsurance	One copayment per pregnancy for both office visits and childbirth/delivery professional services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$50/pregnancy sdeductible does not apply	$100/pregnancy deductible does not apply	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 In-Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Not covered	60 visit limit In and Out of Network combined.
	Rehabilitation services	$50/visit Specialist deductible does not apply	$100/visit Specialist deductible does not apply	50% coinsurance	Up to 20 visits each for physical, occupational and speech therapy per calendar year In and Out- of-Network combined.
	Habilitation services	$50/visit Specialist deductible does not apply	$100/visit Specialist deductible does not apply	50% coinsurance	Up to 20 visits each for physical, occupational and speech therapy per calendar year In and Out- of-Network combined.
	Skilled nursing care	20% coinsurance	40% coinsurance	50% coinsurance	Up to 60 days per calendar year In and Out- of-Network combined.
	Durable medical equipment	20% coinsurance	40% coinsurance	Not covered	
	Hospice services	20% coinsurance	40% coinsurance	50% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	--------none--------
	Children's glasses	Not covered	Not covered	Not covered	--------none--------
	Children's dental check-up	Not covered	Not covered	Not covered	--------none--------

Excluded Services & Other Covered Services:

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

- Bariatric surgery
- Dental Check-up
- Hearing aids (Ages 18+)
- Preauthorization - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. To find out which services require Preauthorization and to be sure that Preauthorization has been given, you may contact us.
- Routine foot care unless you have been diagnosed with diabetes.
- Cosmetic surgery
- Eye exams for a child
- Infertility treatment
- Private-duty nursing
- Weight loss programs
- Dental care (adult)
- Glasses for a child
- Long- term care
- Routine eye care (adult)
- Elective abortion

* For more information about limitations and exceptions, see **plan** or policy document at https://eoc.anthem.com/eocdps/fi.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Most coverage provided outside the United States. See www.bcbsglobalcore.com	• Acupuncture 20 visits/benefit period.	• Chiropractic care 20 visits/benefit period.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490. Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

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

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

About these Coverage Examples:

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

- **The plan's overall deductible** — **$1,500**
- **Specialist *copayment*** — **$25**
- **Hospital (facility) *coinsurance*** — **20%**
- **Other *coinsurance*** — **0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$250
Coinsurance	$1,750
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

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

- **The plan's overall deductible** — **$1,500**
- **Specialist *copayment*** — **$25**
- **Hospital (facility) *coinsurance*** — **20%**
- **Other *coinsurance*** — **0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$2,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,255**

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

- **The plan's overall deductible** — **$1,500**
- **Specialist *copayment*** — **$25**
- **Hospital (facility) *coinsurance*** — **20%**
- **Other *coinsurance*** — **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$841
Copayments	$830
Coinsurance	$188
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,859**

The plan would be responsible for the other costs of these EXAMPLE covered services.

(855) 333-5735 ¶

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Appendix A
Colorado Supplement to the Summary of Benefits and Coverage Form

Insurance Company Name	Anthem Blue Cross and Blue Shield
Name of Plan	WellChoice PPO 11
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Preferred Provider Organization (PPO)*
3. Areas of Colorado where plan is available	Plan is available throughout Colorado.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

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

	Description
4. Annual Deductible Type	SINGLE – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met. FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by [2] or more individuals.
5. Out-of-Pocket Maximum	SINGLE – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met. FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by [2] or more individuals.
6. What is included in the In- Network Out-of-Pocket Maximum?	Most In-Network Copays and Coinsurance. Not included in the Out-of-Pocket Maximum for this plan are Pre-Authorization Penalties, Services in excess of allowed benefit (benefit cap), Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.
7. Is pediatric dental covered by this plan?	No, the plan does not include pediatric dental.

8. What cancer screenings are covered?	The following screenings are covered under your benefits subject to the terms and conditions of your certificate of coverage: Routine colorectal cancer screenings and colonoscopies, Mammogram Screenings, Pap tests and Prostate Cancer Screenings.

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, you will be responsible for paying the difference between the Maximum Allowed Amount and the non-participating Provider's Billed Charges (sometimes called "Balance billing"). The amounts you pay for Out-of-Network Covered Services are in addition to your balance billing costs.
10. Does the plan have a binding arbitration clause?	Yes.	

Questions: Call **(855) 333-5735** or visit us at http://www.anthem.com
If you are not satisfied with the resolution of your complaint or grievance, contact:
Call: 303-894-7490 (in-State, toll-free: 800-930-3745)
Consumer Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Colorado Division of Insurance:
Email:dora_insurance@State.co.us

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 333-5735.