Anthem Colorado Option Gold Pathway Std

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/033MIND01012027. 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) 453-7031 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,400/person or $4,800/family for In-Network Providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Primary Care. Specialist Visit. Preventive Care. Certain Prescription Drugs. Vision. For more information see below.	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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$10,450/person or $20,900/family for In-Network Providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.anthem.com/find-care/?alphaprefix=P7F or call (855) 453-7031 for a list of network providers. Benefits and costs may vary by site of service and how the provider bills.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an Out-of-Network Provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an Out-of-Network Provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-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	$0/visit, deductible does not apply	Not covered	Virtual visits (Telehealth) benefits available.
	Specialist visit	$55/visit, deductible does not apply	Not covered	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	No charge, deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not covered	--------none--------
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.anthem.com/pharmacy-information/.	Preventive Care Drugs (Tier 1)	No charge, deductible does not apply	Not covered (retail and home delivery)	Precertification may be required for certain Prescription Drugs. Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. For more information, refer to "Select Drug List" at https://www.anthem.com/pharmacy-information/. *See Prescription Drug section of your evidence of coverage, available in the footnote below.
	Typically Generic (Tier 2)	$10/prescription, deductible does not apply (retail) and $30/prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)	
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 3)	$50/prescription, deductible does not apply (retail) and $150/prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 4)	$200/prescription, deductible does not apply (retail) and $600/prescription, deductible does not apply (home delivery)	Not covered (retail and home delivery)	
	Typically Preferred Specialty (brand and generic) (Tier 5)	$600/prescription, deductible does not apply (retail and home delivery)	Not covered (retail and home delivery)	

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/033MIND01012027.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	--------none--------
	Physician/surgeon fees	30% coinsurance	Not covered	--------none--------
If you need immediate medical attention	Emergency room care	30% coinsurance	Covered as In-Network	--------none--------
	Emergency medical transportation	30% coinsurance	Covered as In-Network	Non-emergency Out-of-Network Ambulance Services are limited to $50,000 per trip, does not apply to air ambulance.
	Urgent care	$50/visit, deductible does not apply	Covered as In-Network	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not covered	60 days/benefit period for Inpatient rehabilitation for In-Network Providers.
	Physician/surgeon fees	30% coinsurance	Not covered	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit No charge, deductible does not apply Other Outpatient 30% coinsurance	Office Visit Not covered Other Outpatient Not covered	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------
	Inpatient services	30% coinsurance	Not covered	--------none--------
If you are pregnant	Office visits	$0/visit, deductible does not apply	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	30% coinsurance	Not covered	
	Childbirth/delivery facility services	30% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	28 hours/week for Home Health and Private Duty Nursing combined for In-Network Providers.
	Rehabilitation services	30% coinsurance	Not covered	20 visits each for Physical, Speech and Occupational therapy/ benefit period for In-Network Providers.
	Habilitation services	30% coinsurance	Not covered	20 visits each for Physical, Speech and Occupational

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/033MIND01012027.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				therapy/ benefit period for In-Network Providers.
	Skilled nursing care	30% coinsurance	Not covered	100 days/benefit period for skilled nursing services for In-Network Providers.
	Durable medical equipment	30% coinsurance	Not covered	*See Durable Medical Equipment section.
	Hospice services	30% coinsurance	Not covered	--------none--------
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	Not covered	Coverage is limited to 1 exam per benefit period for In-Network Providers. *See Vision Services section of your evidence of coverage, available in the footnote below.
	Children's glasses	No charge, deductible does not apply	Not covered	Coverage is limited to 1 unit per benefit period for In-Network Providers. *See Vision Services section of your evidence of coverage, available in the footnote below.
	Children's dental check-up	0% coinsurance	Not covered	Coverage is limited to 2 visits per 12 months for In-Network Providers.

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.)

- Cosmetic surgery
- Long-term care
- Routine foot care
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Hearing aids (18+)
- Routine eye care (Adult)

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/033MIND01012027.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion (including Non-Hyde Abortion Services) • Chiropractic care 20 visits/benefit period	• Acupuncture 6 visits/benefit period • Infertility treatment	• Bariatric surgery • Private-duty nursing Facility Setting no limit and 28 hours/week combined with Home Health

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, or contact Anthem at the number on the back of your ID card. 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 on how 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

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

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable.
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:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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

The plan's overall deductible	$2,400
Specialist copayment	$55
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,400
Copayments	$10
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,470**

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

The plan's overall deductible	$2,400
Specialist copayment	$55
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

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

The plan's overall deductible	$2,400
Specialist copayment	$55
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,400
Copayments	$200
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,620**

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

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խնդիրներ ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

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

Insurance Company Name	Anthem® BlueCross and BlueShield
Name of Plan	Anthem Colorado Option Gold Pathway Std
1. Type of Policy	Individual Policy
2. Type of plan	Health maintenance organization (HMO)*
3. Areas of Colorado where plan is available	All counties except: Adams, Arapahoe, Archuleta, Boulder, Broomfield, Clear Creek, Denver, Douglas, Eagle, Elbert, Gilpin, Jefferson, La Plata, Mesa, Moffat, Montezuma, Park, Rio Blanco, Routt, and Summit counties.

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	EMBEDDED DEDUCTIBLE INDIVIDUAL – 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.

*Network access plans are available on request at the Member Services number on your member ID card or can be obtained by going to www.anthem.com/co/networkaccess. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.