



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 www.anthem.com or by calling 1-800-542-9402.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$500 individual / \$1,500 family	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 <u>deductibles</u> for specific services?	Yes. \$100 for Tiers 2 and 3 prescription drugs per person. 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.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$2,500 individual / \$7,500 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 <u>out-of-pocket limit</u> ?	Premiums and health care this plan doesn't cover and prescription drug copays.	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 any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of in-network providers , see www.anthem.com or call 1-800-542-9402.	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 <u>specialist</u> ?	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 .

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- **Copayments** are fixed dollar amounts (for example, \$25) 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 encourages you to use **in-network providers** by only allowing **in-network** benefits, except in the case of a medical emergency.

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 <u>provider’s</u> office or clinic	Primary care and OB/GYN visit to treat an injury or illness	\$25/visit plus 10% coinsurance after deductible for all other services	Not covered	Coinsurance after deductible charged for any services not billed as an office visit.
	Specialist visit	\$40/visit plus 10% coinsurance after deductible for all other services	Not covered	Coinsurance after deductible charged for any services not billed as an office visit.
	Other practitioner office visit	\$40/visit plus 10% coinsurance after deductible for all other services	Not covered	Chiropractic care and massage therapy services are limited to a combined 20 visits per year. Acupuncture limited to 20 visits per year. Nutritional counseling is limited to 4 visits per year. Coinsurance after deductible charged for any services not billed as an office visit.
	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 copayment (100% covered)	Not covered	Infertility diagnostic services are covered. Bariatric surgery has a per occurrence maximum payment of \$15,000 per member for services received from a designated facility or a per occurrence maximum benefit of \$1,500 from a facility that it not a designated facility.

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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
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.anthem.com	Tier 1 Generic drugs	\$10/prescription (Retail/Mail order)	Not covered	Retail includes a 30-day supply; Mail order includes a 90-day supply.
	Tier 2 Preferred brand drugs	\$40/prescription (Retail), or \$80/prescription (Mail order)	Not covered	Retail includes a 30-day supply; Mail order includes a 90-day supply. Tier 2 and tier 3 outpatient drugs are subject to a \$100 deductible per person, once satisfied then services are subject to the copayment.
	Tier 3 Non-preferred brand drugs	\$60/prescription (Retail), or \$120/prescription (Mail order)	Not covered	Retail includes a 30-day supply; Mail order includes a 90-day supply. Tier 2 and tier 3 outpatient drugs are subject to a \$100 deductible per person, once satisfied then services are subject to the copayment.
	Tier 4 drugs	20% copayment with a maximum of \$150/per 30-day supply (Retail), or \$300/per 90 day supply (Mail order)	Not covered	Certain specialty drugs must be ordered through a specialty pharmacy; see the contract plan for details. Specialty drugs are not eligible for the 90 day mail order program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	Not covered	10% coinsurance also applies to second surgical opinion.
	Physician/surgeon fees	10% coinsurance after deductible	Not covered	—————none—————

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City and County of Broomfield: HMO DED

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

Coverage Period: 01/1/2014 – 12/31/2014

Coverage for: Individual/Family | Plan Type: HMO

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	\$150/visit plus 10% coinsurance after deductible	\$150 copay plus 10% coinsurance after deductible	\$150 copay is waived if patient is admitted.
	Emergency medical transportation	\$100/trip	\$100/trip	—————none—————
	Urgent care	\$40/visit	\$40/visit	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	Not covered	—————none—————
	Physician/surgeon fee	10% coinsurance after deductible	Not covered	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office visit: \$25 copay; Facility services: no copayment (100% covered)	Not covered	—————none—————
	Mental/Behavioral health inpatient services	10% coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
	Substance use disorder outpatient services	Office visit: \$25 copay; Facility services: no copayment (100% covered)	Not covered	—————none—————
	Substance use disorder inpatient services	10% 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	\$25 copayment for the first prenatal office visit plus 10% coinsurance after deductible for remaining prenatal care	Not covered	—————none—————
	Delivery and all inpatient services	10% coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.

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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 deductible	Not covered	Home health care is limited to 100 visits per year.
	Rehabilitation services	Inpatient: 10% coinsurance after deductible; Outpatient: \$25/visit for a Primary Care Physician and Physical Therapist, or \$40/visit for a Specialist	Not covered	Outpatient coverage of physical, occupational and speech therapies is limited to 60 visits each per year, combined in- and out-of-network. Inpatient benefit for therapies is limited to 30 non-acute days per year, in- and out-of-network combined.
	Habilitation services	Inpatient: 10% coinsurance after deductible; Outpatient: \$25/visit for a Primary Care Physician and Physical Therapist, or \$40/visit for a Specialist	Not covered	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	10% coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage. Covers up to 100 days per year combined in- and out-of-network.
	Durable medical equipment	10% coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
	Hospice service	10% coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
If your child needs dental or eye care	Eye exam	\$20/visit	Not covered	Annual exam only.
	Glasses	Not covered	Not covered	—————none—————
	Dental check-up	Not covered	Not covered	—————none—————

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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.)

- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care
- 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)
- Bariatric surgery (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 1-800-542-9402. 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.

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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:

HMO Colorado, Complaints and Appeals
700 Broadway
Denver, CO 80273
800-542-9402

Additionally, if you are dissatisfied with the denial of an appeal, you can contact:

Broomfield Human Resources
Attention: Director of Human Resources
One DesCombes Drive
Broomfield, CO 80020

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.**

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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 adoolwoł iínizinigo t'áá diné k'éjíggo, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíłkiid. Eí doo biigha daago ni ba'nija'go ho'aalágí bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígí ní béesh bee hane'í wólta' bi'ki si'niilígí bi'kéhgo bich'í hodiilní.

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

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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 \$6,315**
- **Patient pays \$1,225**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions (Tiers 2 and 3)	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles (includes prescriptions)	\$600
Copays	\$25
Coinsurance	\$600
Limits or exclusions	\$0
Total	\$1,225

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$4,140**
- **Patient pays \$1,260**

Sample care costs:

Prescriptions (Tiers 2 and 3)	\$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 (includes prescriptions)	\$600
Copays	\$580
Coinsurance	\$80
Limits or exclusions	\$0
Total	\$1,260

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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**, benefits would only be payable for medical emergencies.

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 flexible spending arrangements (FSAs) that help you pay out-of-pocket expenses.

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