Anthem Blue Cross and Blue Shield
Anthem Silver Pathway X HMO 150/35% S06

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

Coverage Period: 01/01/2015 – 12/31/2015
Coverage for: Individual + Family | **Plan Type:** HMO

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/sbc or by calling (855) 453-7031.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$150** person / **$300** family for In-Network Provider. Does not apply to Preventive Care.	You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes; **$600** person / **$1,200** family for In-Network Provider.	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 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of In-Network providers, see www.anthem.com or call **(855) 453-7031**. Dental and Vision benefits may access a different network of 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 3 for how this plan pays different kinds of **providers**.
Do I need a referral to	No; You do not need a referral	You can see the **specialist** you choose without permission from this plan.

Questions: Call (855) 453-7031 or visit us at www.anthem.com
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (855) 453-7031 to request a copy.

Important Questions	Answers	Why this Matters:
see a specialist?	to see a specialist.	
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 a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay per visit for the first 2 visits and then 35% coinsurance	Not covered	All office visit copayments count towards the same 2 visit limit.
	Specialist visit	35% coinsurance	Not covered	--------none--------
	Other practitioner office visit	Spinal Manipulation Not covered Acupuncture Not covered	Spinal Manipulation Not covered Acupuncture Not covered	Spinal Manipulation --------none-------- Acupuncture --------none--------
	Preventive care/screening/immunization	No charge	Not covered	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 35% coinsurance X-Ray – Office 35% coinsurance	Lab – Office Not covered X-Ray – Office Not covered	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	35% coinsurance	Not covered	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinfor	Tier 1 - Typically Generic	$10 copay per prescription (retail only) and $20 copay per prescription (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. Maintenance medications are subject to mandatory home delivery services after the initial supply has been dispensed at a retail pharmacy. Applies to all tiers.
	Tier 2 - Typically Preferred/Formulary	$25 copay per	Not covered	Covers up to a 30 day supply (retail

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
mation/ Anthem Select Drug List	Brand	prescription (retail only) and $62.50 copay per prescription (home delivery only)		pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
	Tier 3 - Typically Non-preferred/Non-formulary and Specialty Drugs	35% coinsurance (retail and home delivery)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
	Tier 4 - Typically Specialty Drugs	35% coinsurance (retail and home delivery)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% coinsurance	Not covered	--------none--------
	Physician/surgeon fees	35% coinsurance	Not covered	--------none--------
If you need immediate medical attention	Emergency room services	$75 copay per visit and then 35% coinsurance	Covered as In-Network	Copay waived if admitted.
	Emergency medical transportation	35% coinsurance	Covered as In-Network	--------none--------
	Urgent care	$25 copay per visit and then 35% coinsurance	Covered as In-Network	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 copay per admission and then 35% coinsurance	Not covered	Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs In-Network Providers is limited to 60 days per benefit period.
	Physician/surgeon fee	35% coinsurance	Not covered	--------none--------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit 35% coinsurance Mental/Behavioral Health Facility Visit-Facility Charges	Mental/Behavioral Health Office Visit Not covered Mental/Behavioral Health Facility Visit-Facility Charges	Mental/Behavioral Health Office Visit --------none-------- Mental/Behavioral Health Facility Visit-Facility Charges --------none--------

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
		35% coinsurance	Not covered	
	Mental/Behavioral health inpatient services	$150 copay per admission and then 35% coinsurance	Not covered	--------none--------
	Substance use disorder outpatient services	Substance Abuse Office Visit 35% coinsurance Substance Abuse Facility Visit -Facility Charges 35% coinsurance	Substance Abuse Office Visit Not covered Substance Abuse Facility Visit -Facility Charges Not covered	Substance Abuse Office Visit --------none-------- Substance Abuse Facility Visit -Facility Charges --------none--------
	Substance use disorder inpatient services	$150 copay per admission and then 35% coinsurance	Not covered	--------none--------
If you are pregnant	Prenatal and postnatal care	35% coinsurance	Not covered	--------none--------
	Delivery and all inpatient services	$150 copay per admission and then 35% coinsurance	Not covered	Applies to inpatient facility. Other cost shares may apply depending on services provided.
If you need help recovering or have other special health needs	Home health care	35% coinsurance	Not covered	Coverage for In-Network Providers is limited to 28 hours per week.
	Rehabilitation services	35% coinsurance	Not covered	Coverage for Speech Therapy is limited to 40 visits per benefit period, Occupational Therapy is limited to 40 visits per benefit period, and Physical Therapy is limited to 40 visits per benefit period. Apply to In-Network Providers.
	Habilitation services	35% coinsurance	Not covered	Habilitation and Rehabilitation visits count towards your Rehabilitation limit.
	Skilled nursing care	35% coinsurance	Not covered	Coverage for In-Network Providers is limited to 100 days per benefit period.
	Durable medical equipment	35% coinsurance	Not covered	--------none--------
	Hospice service	35% coinsurance	Not covered	--------none--------
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage for In-Network Providers is limited to 1 exam per benefit period.
	Glasses	No charge	Not covered	Coverage for In-Network Providers is

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
				limited to 1 unit per benefit period.
	Dental check-up	10% coinsurance	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult). This policy does not provide any dental benefits to individuals age nineteen (19) or older except as specifically covered in your evidence of coverage. This policy is being offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. If you want adult dental benefits, you will need to buy a plan that has adult dental benefits. This plan will not pay for any adult dental care, so you will have to pay the full price of any care you receive.
- Hearing aids (Ages 18+)
- Infertility treatment
- Long-term care
- Non-Formulary drugs
- Routine eye care (Adult)
- Routine foot care
- Spinal Manipulation
- 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.)

- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide.
- Private-duty nursing

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (855) 453-7031. You may also contact your state insurance department at:

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

Your Grievance and Appeals Rights:

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

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

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

Does this Coverage Provide Minimum Essential Coverage?

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

Language Access Services:

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

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

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

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

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

About These Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,900
- **Patient pays** $640

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	$200
Copays	$40
Coinsurance	$400
Limits or exclusions	$0
Total	$640

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,560
- **Patient pays** $840

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	$200
Copays	$400
Coinsurance	$40
Limits or exclusions	$200
Total	$840

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

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Anthem BlueCross BlueShield

Colorado Supplement to the Summary of Benefits and Coverage Form
Anthem BlueCross BlueShield
Anthem Silver Pathway X HMO 150/35% S06

TYPE OF COVERAGE

1. Type of plan	Health maintenance organization (HMO)
2. Out-of-network care covered?[1]	Only for emergency and urgent care.
3. Areas of Colorado where plan is available	Plan is available throughout Colorado.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

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

	Description	What this means
4. Deductible Period	Calendar Year	Calendar year deductibles restart each January 1.
5. Annual Deductible Type	Member/Family	"Member" means the deductible amount you and each member covered by the plan will have to pay for allowable covered expenses before the carrier will cover these expenses. "Family" is the maximum deductible amount that is required to be met for all family members covered by the plan. It may be an aggregated amount (e.g. $3000 per family) or specified and the number of individual deductibles that must be met (e.g. "3 deductibles per family").
6. What cancer screenings are covered?	The following screenings are covered under your benefits subject to the terms and conditions of your certificate of coverage: Pap Tests, Mammogram Screenings, Prostate Cancer Screening, and Colorectal Cancer Screening.	

LIMITATIONS AND EXCLUSIONS

7. Period during which pre-existing conditions are not covered for covered persons age 19 and older? [2]	NA months for all pre-existing conditions.
8. How does the policy define a "pre-existing condition"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.
9. Exclusionary Riders: Can an individual's specific, pre-existing conditions be entirely excluded from the policy?	No

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
10. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, out-of network care is not covered except as noted.
11. Does the plan have a binding arbitration clause?	Yes	

Questions: Call **(888) 231-5046** or visit us at http://www.anthem.com
If you are not satisfied with the resolution of your complaint or grievance, contact
Colorado Division of Insurance
Consumer Affairs Section
1560 Broadway, Suite 850
Denver, CO 80202
Call 303-894-7490 (in-state toll-free 800-830-3745)
Email: insurance@dora.state.co.us

If you need assistance to understand this document in Spanish, you may request it at no additional cost by calling the customer service number above.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número que aparece arriba.

Endnotes

[1] "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that this plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

[2] Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.