Anthem Bronze PPO

9200/0%/9200

Contract code: 83UW

Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your 2025 Contract Code: 83UW

Your Plan: Anthem Bronze PPO 9200/0%/9200

Your Network: Anthem PPO*

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. Unless stated otherwise, the limitations for In- and Out-of-Network services are combined and services received in an office, Ambulatory Surgical Center, or outpatient facility are combined across all outpatient settings. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	No charge after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$9,200 person / $18,400 family	$27,600 person / $55,200 family
Overall Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period.*	$9,200 person / $18,400 family	$32,200 person / $64,400 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per member deductible or per member out-of-pocket limit. *In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.* *All medical services subject to a coinsurance are also subject to the annual medical deductible.* *Your copays, coinsurance and deductible count toward your out-of-pocket limit. However, member cost sharing for the following service(s) do not apply toward the out-of-pocket limit: adult vision, Out-of-Network Human Organ and Tissue Transplant and Cellular and Gene Therapy.*		
Doctor Visits (virtual and office) *Your plan requires the selection of a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	No charge after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Specialist Care *virtual and office*	No charge after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery) *In-Network preventive prenatal services are covered at 100%.*	No charge after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic	No charge after deductible is met	50% coinsurance after deductible is met
Chiropractic *Coverage is limited to 20 visits per benefit period.*	No charge after deductible is met	Not covered
Acupuncture *Coverage is limited to 20 visits per benefit period combined for Acupuncture and Massage Therapy.*	No charge after deductible is met	Not covered
Other Services in an Office		
Allergy Testing	No charge after deductible is met	50% coinsurance after deductible is met
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection.*	No charge after deductible is met	50% coinsurance after deductible is met
Surgery	No charge after deductible is met	50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	No charge after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	No charge after deductible is met	50% coinsurance after deductible is met
X-Ray		
Office	No charge after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans		
Office	No charge after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care (Office Setting)	No charge after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	No charge after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge after deductible is met	Covered as In-Network
Ambulance (Air and Ground) *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	No charge after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Doctor Services	No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	No charge after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	No charge after deductible is met	50% coinsurance after deductible is met
Physician and other services including surgeon fees		
Hospital	No charge after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	No charge after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)		
Facility fees (for example, room & board) *Rehabilitation services in an inpatient hospital or acute care facility are limited to 60 days combined per benefit period.*	No charge after deductible is met	50% coinsurance after deductible is met
Physician and other services including surgeon fees	No charge after deductible is met	50% coinsurance after deductible is met
Home Health Care *Coverage is limited to 28 hours per week. Visit limit does not apply to Home Infusion Therapy or Home Dialysis. Limits are combined for home health care and private duty nursing.*	No charge after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy) *Coverage for occupational therapy is limited to 20 visits per benefit period, physical therapy is limited to 20 visits per benefit period and speech therapy is limited to 20 visits per benefit period.*		
Office	No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	50% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy)		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Coverage for occupational therapy is limited to 20 visits per benefit period, physical therapy is limited to 20 visits per benefit period and speech therapy is limited to 20 visits per benefit period.		
Office	No charge after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	No charge after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation office and outpatient hospital	No charge after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation office and outpatient hospital	No charge after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis office and outpatient hospital	No charge after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy office and outpatient hospital	No charge after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 100 days per benefit period.*	No charge after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	No charge after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	No charge after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Coverage for hearing aids and services for children under 18 years of age is limited to 1 item per ear every 5 years.*	No charge after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***Select*** *Drugs not included on the Select drug list will not be covered. Prescription Drugs that we are required to cover by federal law under the "Preventive Care" benefit will be covered with no deductible, copayments or coinsurance when you use an In-Network Pharmacy.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (cost shares noted below)* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.*		
Tier 1 - Typically Generic	0% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	0% coinsurance after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's vision services count towards your out-of-pocket limit.		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	Not applicable	Not applicable
Vision exam *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.*	No charge	No charge
Frames *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.*	No charge	Not covered
Single Vision Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	Not covered
Bifocal Vision Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	Not covered
Trifocal Vision Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	Not covered
Elective contact lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.*	No charge	Not covered
Non-Elective Contact Lenses *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.*	No charge	Not covered
Adult Vision (age 19 and older)		
Adult Vision Deductible	Not applicable	Not applicable
Vision exam *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 exam per benefit period.*	$20 copay	Reimbursed Up to $30
Frames *Coverage for In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.*	$130 Allowance	Reimbursed Up to $45
Single Vision Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	Reimbursed Up to $25
Bifocal Vision Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	Reimbursed Up to $40

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Trifocal Vision Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	Reimbursed Up to $55
Elective contact lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.*	$80 Allowance	Reimbursed Up to $60
Non-Elective Contact Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Out-of-Network Providers is limited to 1 unit every 2 benefit periods.*	No charge	Reimbursed Up to $210

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. Only children's dental services count towards your out-of-pocket limit.		
Children's Dental Essential Health Benefits		
Diagnostic and preventive *Coverage for In-Network Providers and Out-of-Network Providers is limited to 2 visits per 12 months.*	No charge	30% coinsurance deductible does not apply
Basic services	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Major services	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Medically Necessary Orthodontia services	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Combined with medical deductible
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Annual maximum	Not covered	Not covered

Healthy Support & Rewards

To see your rewards and additional information log into the Anthem website at anthem.com or call the customer service number on your member ID card.

Program Name	Program Description	Program Incentive
Smart Rewards (Wellbeing Solutions Engagement Package 200)	Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.	Up to $200 per member per year
Gym Reimbursement	Subscriber, spouse, and dependents age 18 and over can get money back for using a gym. Fitness membership dues, up to $400, are covered if you're a member of this plan. Work out 50 times at a qualifying fitness center for each six-month period within your benefit plan year. Benefit plan year is the yearly period of coverage that starts at the effective date of coverage.	

Notes:

- Benefit period refers to both calendar year and plan year.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- If services are rendered by a non-participating provider and your plan includes Out-of-Network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating provider's charge.
- *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.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- This health plan includes an Employee Assistance Program (EAP) to support your emotional health and wellness with work life resources, including one-on-one counseling by phone, in person and online. Three counseling visits are available at no charge to a member. EAP member service is accessible 24/7/365.

Questions: (855) 837-8536 or visit us at www.anthem.com

CO/SG/Anthem Bronze PPO 9200/0%/9200/83UW/01-01-2025

Anthem Bronze PPO

Contract code: 83UW

Summary of Cost and Coverage

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/83UWSMG01012025. 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) 837-8536 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$9,200/person or $18,400/family for In-Network Providers. $27,600/person or $55,200/family for Out-of-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. Preventive Care. 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?	$9,200/person or $18,400/family for In-Network Providers. $32,200/person or $64,400/family for Out-of-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, health care this plan doesn't cover, and Out-of-Network Transplants.	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=VAD or call (855) 837-8536 for a list of network providers. Costs may	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

	vary by site of service and how the provider bills.	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% coinsurance	50% coinsurance	Virtual visits (Telehealth) benefits available.
	Specialist visit	0% coinsurance	50% coinsurance	Virtual visits (Telehealth) benefits available.
	Preventive care/screening/ immunization	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 pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	--------none--------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.anthem.com/pharmacyinformation/	Typically Generic (Tier 1)	0% coinsurance (retail and home delivery)	50% coinsurance (retail) and Not covered (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 http://www.anthem.com/pharmacyinformation/ Preventive Care drugs are covered in full regardless of tier. *See Prescription Drug section of your evidence of coverage, available in the footnote below.
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	0% coinsurance (retail and home delivery)	50% coinsurance (retail) and Not covered (home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	0% coinsurance (retail and home delivery)	50% coinsurance (retail) and Not covered (home delivery)	
	Typically Preferred Specialty (brand and generic) (Tier 4)	0% coinsurance (retail and home delivery)	50% coinsurance (retail) and Not covered (home delivery)	

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/83UWSMG01012025.

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)	0% coinsurance	50% coinsurance	--------none--------
	Physician/surgeon fees	0% coinsurance	50% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	0% coinsurance	Covered as In-Network	--------none--------
	Emergency medical transportation	0% coinsurance	Covered as In-Network	Non-emergency Out-of-Network Ambulance Services are limited to $50,000 per trip.
	Urgent care	0% coinsurance	50% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	60 days/benefit period for Inpatient rehabilitation.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 0% coinsurance Other Outpatient 0% coinsurance	Office Visit 50% coinsurance Other Outpatient 50% coinsurance	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient --------none--------
	Inpatient services	0% coinsurance	50% coinsurance	--------none--------
If you are pregnant	Office visits	0% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	28 hours/week for Home Health and Private Duty Nursing combined.
	Rehabilitation services	0% coinsurance	50% coinsurance	20 visits each for Physical, Speech and Occupational therapy/benefit period.
	Habilitation services	0% coinsurance	50% coinsurance	20 visits each for Physical, Speech and Occupational therapy/benefit period.
	Skilled nursing care	0% coinsurance	50% coinsurance	100 days/benefit period for skilled nursing services.
	Durable medical equipment	0% coinsurance	50% coinsurance	*See Durable Medical Equipment section.
	Hospice services	0% coinsurance	50% coinsurance	--------none--------

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/83UWSMG01012025.

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 your child needs dental or eye care	Children's eye exam	No charge	No charge	Coverage is limited to 1 exam per benefit period. *See Vision Services section of your evidence of coverage, available in the footnote below.
	Children's glasses	$20/unit, deductible does not apply	Not covered	Coverage is limited to 1 unit every 2 benefit periods. *See Vision Services section of your evidence of coverage, available in the footnote below.
	Children's dental check-up	No charge	30% coinsurance deductible does not apply	Coverage is limited to 2 visits per 12 months.

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
- Dental care (Adult)
- Hearing aids (18+)
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture 20 visits/benefit period combined with Massage Therapy (In-Network)
- Bariatric surgery
- Chiropractic care 20 visits/benefit period (In-Network)
- Infertility treatment (In-Network)
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Private-duty nursing Facility Setting no limit and 28 hours/week combined with Home Health
- Routine eye care (Adult) 1 exam/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, or contact Anthem at the number on the back of your ID card.

* For more information about limitations and exceptions, see the plan or policy document at https://eoc.anthem.com/eocdps/83UWSMG01012025.

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** **$9,200**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$9,200
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$9,260**

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

- **The plan's overall deductible** **$9,200**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,420**

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

- **The plan's overall deductible** **$9,200**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

Anthem BlueCross BlueShield

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

Insurance Company Name	Anthem® BlueCross and BlueShield
Name of Plan	Anthem Bronze PPO 9200/0%/9200
1. Type of Policy	Small 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	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.
5. Out-of-Pocket Maximum	EMBEDDED OUT-OF-POCKET INDIVIDUAL – 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.

*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.

6. What is included in the In-Network Out-of-Pocket Maximum?	Any In-Network Deductible, Copays and Coinsurance on Covered Services, except dental or vision services for members 19 or older.
7. Is pediatric dental covered by this plan?	Yes, pediatric dental is subject to the medical deductible and out-of-pocket.
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: Pap tests, Mammogram Screenings, Prostate Cancer Screenings and Routine colorectal cancer screenings and colonoscopies.

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 **(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 Services, Life and Health Section
1560 Broadway, Suite 850, Denver, CO 80202
Call: 303-894-7490 (in-State, toll-free: 800-930-3745)
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 (888) 231-5046.

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