

Trinidad Benham BlueClassic PPO 11 Traditional Plan



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/aso>. 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 (877) 811-3106 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$1,000/member or \$2,000/family for In- Network Providers . \$2,000/member or \$4,000/family for Non- Network Providers . | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Yes. Primary Care. Specialist Visit . Preventive Care . Certain Prescription Drugs . 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 ? | \$4,000/member or \$8,000/family for In- Network Providers . \$11,200/member or \$22,400/family for Non- Network Providers . | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Pre-Authorization Penalties, Premiums , balance-billing 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 . |
| Will you pay less if you use a network provider ? | Yes, PPO. See www.anthem.com or call (877) 811-3106 for a list of network providers . 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) | Non-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$25/visit deductible does not apply | 40% coinsurance | Other cost shares may apply depending on services provided. Virtual visits (Telehealth) benefits available. |
| | Specialist visit | \$50/visit deductible does not apply | 40% coinsurance | Other cost shares may apply depending on services provided. Virtual visits (Telehealth) benefits available. |
| | Preventive care / screening /immunization | No charge | 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) | Office: 20% coinsurance , deductible does not apply Hospital: 20% coinsurance | 40% coinsurance | -----none----- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% 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/ | Tier 1 - Typically Generic | Retail: \$10 copay, deductible does not apply. Mail-Order: \$20 copay, deductible does not apply. | Retail: \$10 copay, deductible does not apply. | 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 “National Direct 4-Tier” at |
| | Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs | Retail: \$30 copay, deductible does not apply. Mail-Order: \$60 copay, deductible does not apply. | Retail: \$30 copay, deductible does not apply. | |

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|---|--|
| | | In-Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| | Tier 3 - Typically Non-Preferred Brand and Generic drugs | \$50 copay, deductible does not apply. Mail-Order: \$100 copay, deductible does not apply. | Retail: \$50 copay, deductible does not apply. | http://www.anthem.com/pharmacyinformation/ *See Prescription Drug Section of your evidence of coverage, available in the footnote below. |
| | Tier 4 - Typically Preferred Specialty (brand and generic) | Retail: 20% with a \$250 maximum. Mail-Order: 20% with a \$500 maximum. | Retail: 20% with a \$250 maximum. | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | Prenotification is required non-network or a penalty of 50% coinsurance after deductible applies. |
| | Physician/surgeon fees | 20% coinsurance Office: 20% coinsurance, deductible does not apply | 40% coinsurance | -----none----- |
| If you need immediate medical attention | Emergency room care | \$150 copay per visit, then 20% coinsurance, deductible does not apply. | Covered as In- Network | -----none----- |
| | Emergency medical transportation | 20% coinsurance, deductible does not apply. | Covered as In- Network | -----none----- |
| | Urgent care | \$50 copay per visit, then 20% coinsurance, deductible does not apply. | 40% coinsurance | Other cost shares may apply depending on services provided. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | \$500 inpatient confinement copay applies to non-network prior to the deductible, a penalty of 50% coinsurance after deductible will apply if prenotification is not obtained. |
| | Physician/surgeon fees | 20% coinsurance Office: | 40% coinsurance | -----none----- |

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|--|
| | | In-Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| | | 20% coinsurance, deductible does not apply | | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit No Charge Other Outpatient 20% coinsurance | Office Visit 40% coinsurance Other Outpatient 40% coinsurance | Office Visit Virtual visits (Telehealth) benefits available at no charge. Other Outpatient -----none----- |
| | Inpatient services | 20% coinsurance | 40% coinsurance | \$500 inpatient confinement copay applies to non-network prior to the deductible, a penalty of 50% coinsurance after deductible will apply if prenotification is not obtained. |
| If you are pregnant | Office visits | No Charge | 40% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). \$500 inpatient confinement copay applies to non-network prior to the deductible, a penalty of 50% coinsurance after deductible will apply if prenotification is not obtained. |
| | Childbirth/delivery professional services | 20% coinsurance Office: 20% coinsurance, deductible does not apply | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 40% coinsurance | Limited to 60 visits per calendar year. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Limits per calendar year: Physical: 25 visits; Occupational: 20 visits; Speech: 20 visits; Cardiac: Unlimited; Pulmonary: Unlimited. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | Habilitation visits count towards your rehabilitation limit. |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Limited to 90 days per calendar year (combined with inpatient |

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| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|----------------------|---|---|---|--|
| | | In-Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| | | | | rehabilitation). \$500 inpatient confinement copay applies to non-network prior to the deductible. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | -----none----- |
| | Hospice services | 20% coinsurance | 40% coinsurance | Prenotification is required non-network or a penalty of 50% coinsurance after deductible applies. |

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.) | | |
|---|---|--|
| <ul style="list-style-type: none"> • Bariatric surgery • Dental care (Pediatric) • Hearing aids (18+) • Routine foot care unless you have been diagnosed with diabetes • Infertility treatment | <ul style="list-style-type: none"> • Cosmetic surgery • Dental Check-up • Long-term care • Weight loss programs • Private Duty Nursing | <ul style="list-style-type: none"> • Dental care (Adult) • Glasses for a child • Preauthorization - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. Contact us to find out what must be preauthorized and whether preauthorization has been given. |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|--|--|--|
| <ul style="list-style-type: none"> • Most coverage provided outside the United States. See www.bcbsglobalcore.com | <ul style="list-style-type: none"> • Chiropractic care 20 visits/benefit period • Acupuncture 20 visits/benefit period | <ul style="list-style-type: none"> • Hearing aids |

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. 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](#)

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

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

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

Does this plan provide Minimum Essential Coverage? Yes/No

[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? Yes/No

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.

* For more information about limitations and exceptions, see [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

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](#) \$1,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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 | \$1,000 |
| Copayments | \$40 |
| Coinsurance | \$1,800 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,900 |

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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 | \$1,300 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,420 |

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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 | \$1,000 |
| Copayments | \$300 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,500 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (877) 811-3106

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በጎረቤት ለማግኘት ሙብት አለዎት። አስተርጓሚ ለማናገር (877) 811-3106 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (877) 811-3106.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (877) 811-3106:

Bassa (Básà wùdù): M̄ dyi dyi-diè-djè b̄é b̄édjé bá céè-djè nià ke dyí ní, ɔ m̄ò ni dyí-b̄èd̄jèin-djè b̄é m̄ ké gbo-kpá-kpá kè b̄ǎ kp̄ǎ djé m̄ bídí-wùdùùn b̄ó pídyi. B̄é m̄ ké wuɖu-zìin-nyò d̄ò gbo wùdù ke, d̄á (877) 811-3106.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (877) 811-3106 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ၎င်း (877) 811-3106 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(877) 811-3106。

Dinka (Dinka): Na n̄ɔŋ thiëc n̄e ke de yā thorë, ke yin n̄ɔŋ loŋ b̄e yi kuony ku w̄er alëu b̄e ḡɛɛr yic yin ne thoŋ du ke cin w̄eu tāäuë ke piny. Te k̄or yin ba jam w̄enë ran ye thok geryic, ke yin c̄ol (877) 811-3106.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (877) 811-3106.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (877) 811-3106 تماس بگیرید.

Language Access Services:

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (877) 811-3106.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (877) 811-3106.

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (877) 811-3106.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (877) 811-3106.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (877) 811-3106.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (877) 811-3106 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (877) 811-3106.

Igbo (Igbo): O bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (877) 811-3106.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (877) 811-3106.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (877) 811-3106.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (877) 811-3106

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには (877) 811-3106 にお電話ください。

Language Access Services:

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