

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Anthem BlueClassic PPO 2 20/40/500/2500/90% DXL/ER Rx Essential Tiered \$15/\$50/\$75/30%

Your Network: PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	\$25 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Overall Deductible</b>	\$0 member / \$0 family	\$2,000 member / \$6,000 family
<b>Overall Out-of-Pocket Limit</b>	\$3,500 member / \$6,850 family	\$8,750 member / \$17,500 family
<p>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.</p> <p>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.</p> <p>In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
<b>Doctor Visits (virtual and office)</b> <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	<b>virtual</b> -No charge <b>office</b> -\$25 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
<b>Specialist Provider</b> <i>virtual and office</i>	\$25 copay per visit medical deductible does not	40% coinsurance after medical deductible is met
<b>Other Practitioner Visits</b>		
<b>Maternity Doctor services</b> (prenatal/postpartum care and delivery)	\$200 copay per pregnancy medical deductible does not apply	40% coinsurance after medical deductible is met
<b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$25 copay per visit medical deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Chiropractic Services</b> <i>Coverage is limited to 20 visits per benefit period.</i>	\$25 copay per visit medical deductible does not apply	Not covered
<b>Acupuncture</b> <i>Coverage is limited to 20 visits per benefit period combined for Acupuncture and Massage Therapy.</i>	\$25 copay per visit medical deductible does not apply	Not covered
<u><b>Other Services in an Office</b></u> <b>Allergy Testing</b>  <b>Prescription Drugs</b> <i>Dispensed in the office</i>  <b>Surgery</b>	No charge  20% coinsurance after medical deductible is met  20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met  40% coinsurance after medical deductible is met  40% coinsurance after medical deductible is met
<b>Preventive care / screenings / immunizations</b>	No charge	40% coinsurance after medical deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	Cost share is based on the setting services are received.
<u><b>Diagnostic Services Lab</b></u> Office  Freestanding Lab  Outpatient Hospital	No charge  No charge  No charge	40% coinsurance after medical deductible is met  40% coinsurance after medical deductible is met  40% coinsurance after medical deductible is met
<u><b>Diagnostic Services X-Ray</b></u> Office  Freestanding Radiology Center  Outpatient Hospital	No charge  No charge  No charge	40% coinsurance after medical deductible is met  40% coinsurance after medical deductible is met  40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><b>Diagnostic Services</b> <b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b>Emergency and Urgent Care</b></p> <p><b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p><b>Emergency Room Facility Services</b> <i>Your copay will be waived if admitted.</i></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b> <i>Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i></p>	<p>\$25 copay per visit medical deductible does not apply</p> <p>\$250 copay per visit and 20% coinsurance medical deductible does not apply</p> <p>20% coinsurance medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b></p> <p><b>Facility Fees</b></p> <p><b>Doctor Services</b></p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b>Outpatient Surgery</b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><b>Physician and other services</b> <i>including surgeon fees</i></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b></p> <p><b>Facility Fees</b></p> <p><b>Physician and other services</b> <i>including surgeon fees</i></p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b><u>Home Health Care</u></b>  <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>Not covered</p>
<p><b><u>Therapy Services</u></b></p> <p><b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i>  <i>Coverage for physical, occupational, and speech therapies is limited to 20 visits each per benefit period. Costs may vary by site of service. Office and outpatient visits count towards your rehabilitation limit.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit  medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>
<p><b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i>  <i>Coverage is limited to 36 visits per benefit period.</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>
<p><b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>
<p><b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Skilled Nursing Care (facility)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b>Inpatient Hospice</b>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<b><u>Additional Services, Equipment and Devices</u></b> <b>Durable Medical Equipment</b>	20% coinsurance after medical deductible is met	Not covered
<b>Prosthetic Devices</b>	20% coinsurance after medical deductible is met	Not covered
<b>Wigs</b> <i>Coverage for wigs is limited to 1 item after cancer treatment up to a \$500 maximum per member.</i>	20% coinsurance after medical deductible is met	Not covered
<b>Hearing Aids</b> <i>Coverage is limited to 1 item per ear every 5 years for members under 18 years of age.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<b>Pharmacy Deductible</b>	Not applicable	Not applicable	Not covered
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Not covered
<b>Prescription Drug Coverage</b> <b>Network: Rx Choice Tiered Network</b> <b>Drug List: Essential</b> <i>Drugs not included on the Essential drug list will not be covered.</i>			
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> 30 day supply (cost shares noted below) <b>Retail 90 Pharmacy</b> 90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies). <b>Home Delivery Pharmacy</b> 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. <b>Specialty Pharmacy</b> 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.			
<b>Tier 1 - Typically Generic</b>	\$10 copay per prescription (retail) and \$25 copay per prescription (home)	\$20 copay per prescription (retail only)	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
	delivery)		
<b>Tier 2 - Typically Preferred Brand</b>	\$35 copay per prescription (retail) and \$87.50 copay per prescription (home delivery)	\$45 copay per prescription (retail only)	Not covered (retail and home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b>	\$70 copay per prescription (retail) and \$175 copay per prescription (home delivery)	\$80 copay per prescription (retail only)	Not covered (retail and home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b>	10% coinsurance up to \$350 per prescription (retail and home delivery)	10% coinsurance up to \$500 per prescription (retail only)	Not covered (retail and home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<i>This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.</i>		
<b>Children's Vision exam (up to age 19)</b> <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount
<b>Adult Vision exam (age 19 and older)</b> <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$42

**Notes:**

- The Primary Care Physician and Specialist office visit cost share applies to both office and facility based office visits for evaluation and management services only.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- 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.
- The representations of benefits in this document are subject to Colorado Division of Insurance (CO DOI) approval and are subject to change.

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. 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 formal 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.*

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This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

## We're here for you – in many languages

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

### Spanish

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

### Chinese

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

### Vietnamese

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

### Korean

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

### Tagalog

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

### Russian

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

### French Creole

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

### Arabic

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

### French

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

### Persian

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

### Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Դարձապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

### Japanese

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

### Italian

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

### German

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

### Polish

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

### Pennsylvania Dutch

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

### TTY/TTD:711

### It's important we treat you fairly

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

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>