

# Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Health Savings Account (HSA-Compatible) PPO Plan 31AE Essential Rx

Your Network: PPO\*

*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.*

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Overall Deductible</b>  <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section. Deductible applies to all medical and pharmacy services unless otherwise noted.</i></p>	<p>\$4,000 member / \$8,000 family</p>	<p>\$8,000 member / \$16,000 family</p>
<p><b>Out-of-Pocket Limit</b>  <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.</i></p>	<p>\$5,500 member / \$11,000 family</p>	<p>\$16,500 member / \$33,000 family</p>
<p><b>Preventive care/screening/immunization</b>  <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i></p>	<p>No charge</p>	<p>40% coinsurance after deductible is met</p>
<p><b>Doctor Home and Office Services</b></p> <p><b>Primary Care Visit to treat an injury or illness</b></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p><b>Specialist Care Visit</b></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>

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<b>Prenatal and Post-natal Care</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Other Practitioner Visits:</b>		
Retail Health Clinic	20% coinsurance after deductible is met	Not covered
Preferred On-line Visit <i>Includes Mental/ Behavioral Health and Substance Abuse</i> <a href="http://www.livehealthonline.com">www.livehealthonline.com</a>	20% coinsurance after deductible is met	Not covered
Chiropractic Services <i>Coverage is limited to 20 visits per benefit period. Applies to In-Network. Limit is combined across professional visits and outpatient facilities.</i>	20% coinsurance after deductible is met	Not covered
Acupuncture <i>Coverage is limited to 20 visits per benefit period combined for Acupuncture and Massage Therapy. Applies to In-Network.</i>	20% coinsurance after deductible is met	Not covered
<b>Other Services in an Office:</b>		
Allergy Testing <i>Costs may vary by site of service.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hemodialysis	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs <i>For the drugs itself dispensed in the office through infusion/injection.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

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<p><b>Diagnostic Services</b></p> <p><b>Lab:</b></p> <p>Office</p> <p>Freestanding Lab</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>X-Ray:</b></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):</b></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

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<b>Emergency and Urgent Care</b> <b>Urgent Care (Office Setting)</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Emergency Room Facility Services</b>  <b>Emergency Room Doctor and Other Services</b>	20% coinsurance after deductible is met	Covered as In-Network
<b>Ambulance (Air and Ground)</b> <i>Non-emergency, Non-Network ambulance transportation services are limited to an Anthem maximum payment of \$50,000 per trip.</i>	20% coinsurance after deductible is met	Covered as In-Network
<b>Outpatient Mental/Behavioral Health and Substance Abuse</b> <b>Doctor Office Visit</b>  <b>Facility visit:</b> Facility Fees  Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Outpatient Surgery</b> <b>Facility Fees:</b> Hospital  Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met

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<p><b>Doctor and Other Services:</b></p> <p>Hospital <i>Costs may vary by site of service.</i></p> <p>Freestanding Surgical Center <i>Costs may vary by site of service.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)</b></p> <p><b>Facility fees (for example, room &amp; board)</b> <i>Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 150 days combined per benefit period.</i></p> <p><b>Doctor and other services</b></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Recovery &amp; Rehabilitation</b></p> <p><b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period. Applies to In-Network. Limits are combined for home health care and private duty nursing.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>Not covered</p>
<p><b>Rehabilitation services (for example, physical/speech/occupational therapy):</b></p> <p>Office <i>Coverage for Physical, Speech, and Occupational therapy is limited to 20 visits each per benefit period. Costs may vary by site of service. Limit is combined In-Network and Non-Network across all outpatient settings.</i></p> <p>Outpatient Hospital <i>Office and outpatient visits count towards your rehabilitation limit.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Habilitation services (for example, physical/speech/occupational therapy):</b></p>		

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<p>Office <i>Habilitation visits count towards your rehabilitation limit.</i></p> <p>Outpatient Hospital <i>Habilitation visits count towards your rehabilitation limit.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b></p> <p>Office <i>Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network.</i></p> <p>Outpatient Hospital <i>Office and outpatient visits count towards your rehabilitation limit.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Skilled Nursing Care (in a facility)</b> <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p><b>Hospice</b></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p><b>Durable Medical Equipment</b></p>	<p>20% coinsurance after deductible is met</p>	<p>Not covered</p>
<p><b>Prosthetic Devices</b> <i>Applies to In-Network. Coverage for hearing aids services is limited to 1 item every 5 years. Covered for children 18 years of age or under. Limit is combined In-Network and Non-Network.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>Not covered</p>

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Pharmacy Deductible</b>  <i>Deductible applies to all pharmacy services unless otherwise noted.</i></p>	Combined with medical deductible	Not covered
<p><b>Pharmacy Out of Pocket</b></p>	Combined with medical out of pocket maximum	Not covered
<p><b>Prescription Drug Coverage</b>  <i>This plan uses an Essential Drug List. Drugs not on the list are not covered. This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</i></p>		
<p><b>Tier 1 - Typically Generic</b>  <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Specialty drug networks must be used for in-network coverage.</i></p>	\$15 copay per prescription after deductible is met (retail) and \$37.50 copay per prescription after deductible is met (home delivery)	Not covered (retail and home delivery)
<p><b>Tier 2 – Typically Preferred Brand</b>  <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Specialty drug networks must be used for in-network coverage.</i></p>	\$50 copay per prescription after deductible is met (retail) and \$150 copay per prescription after deductible is met (home delivery)	Not covered (retail and home delivery)
<p><b>Tier 3 - Typically Non-Preferred Brand</b>  <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Specialty drug networks must be used for in-network coverage.</i></p>	\$70 copay per prescription after deductible is met (retail) and \$210 copay per prescription after deductible is met (home delivery)	Not covered (retail and home delivery)

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<p><b>Tier 4 - Typically Specialty (brand and generic)</b> <i>Covers up to a 30 day supply (retail pharmacy). No coverage for non-formulary drugs. Specialty drug networks must be used for in-network coverage.</i></p>	30% coinsurance up to \$350 per prescription after deductible is met (retail and home delivery)	Not covered (retail and home delivery)



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## Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- Your Plan limits coverage of Prescription Drugs to only those listed on our Essential Drug List. The Essential Drug List includes selected Generic and Brand Name Drugs. A list of the drugs that are covered on the Essential Drug List is available at <https://www.anthem.com/pharmacyinformation/>
- 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](http://www.anthem.com/co/networkaccess)
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.

## Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (855) 333-5735

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (855) 333-5735.

**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՝ (855) 333-5735:

**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(855) 333-5735。

**Farsi (فارسی):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاف، با شماره (855) 333-5735 تماس بگیرید.

**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 (855) 333-5735.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nempòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèpret, rele (855) 333-5735.

**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 (855) 333-5735.

**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、(855) 333-5735 にお電話ください。

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## Language Access Services:

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee nił hodoonih t'áadoo bǫ́ǫ́h ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninizingo kojí' hodíílnih (855) 333-5735.

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (855) 333-5735.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 333-5735 ਤੇ ਕਾਲ ਕਰੋ।

**Russian (Русский):** Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 333-5735.

**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 (855) 333-5735.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (855) 333-5735.

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (855) 333-5735.

### It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.