Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Health Savings Account (HSA-Compatible) PPO Plan 23E 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
Overall Deductible *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.*	$3,000 member / $6,000 family	$6,000 member / $12,000 family
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. See notes section for additional information regarding your out of pocket maximum.*	$5,000 member / $10,000 family	$15,000 member / $30,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	40% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care Visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met

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

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

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

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

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Office *Habilitation visits count towards your rehabilitation limit.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Habilitation visits count towards your rehabilitation limit.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital *Office and outpatient visits count towards your rehabilitation limit.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *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.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	Not covered
Prosthetic Devices *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.*	20% coinsurance after deductible is met	Not covered

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible *Deductible applies to all pharmacy services unless otherwise noted.*	Combined with medical deductible	Not covered
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Not covered
Prescription Drug Coverage *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.*		
Tier 1 - Typically Generic *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.*	20% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand *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.*	20% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand *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.*	20% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic) *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.*	20% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)

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
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.

Language Access Services:

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:

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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 (855) 333-5735.

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih ninízingo kojį' hodíilnih (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.

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