

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Health Savings Account HSA Compatible PPO Plan 28E Essential Rx

Your Network: PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$6,350 member / \$12,700 family	\$10,000 member / \$20,000 family
<b>Overall Out-of-Pocket Limit</b>	\$6,350 member / \$12,700 family	\$19,050 member / \$38,100 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>Your copays, coinsurance and deductible count toward your out of pocket limit(s).</p> <p>In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
<p><b>Doctor Visits (virtual and office)</b> <i>You are encouraged to select a Primary Care Physician (PCP).</i></p>		
<p><b>Medical Chats and Virtual Visits for Primary Care</b> <i>from our Online Provider K Health, through its affiliated Provider groups are covered at No charge after deductible is met.</i></p>		
<p><b>Virtual Visits from online provider LiveHealth Online</b> <i>for urgent/acute medical and mental health and substance abuse care via <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> are covered at No charge after deductible is met.</i></p>		
<p><b>Primary Care (PCP) and Mental Health and Substance Abuse Care</b> <i>virtual and office</i></p>	<p><b>virtual</b>-No charge after deductible is met <b>office</b>-0% coinsurance after deductible is met</p>	50% coinsurance after deductible is met
<p><b>Specialist Care</b> <i>virtual and office</i></p>	0% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><b><u>Other Practitioner Visits</u></b></p>		
<p><b>Routine Maternity Care</b> (Prenatal and Postnatal)</p>	0% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p>	0% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Chiropractic Services</b> <i>Coverage is limited to 20 visits per benefit period.</i>	0% coinsurance after deductible is met	Not covered
<b>Acupuncture</b> <i>Coverage is limited to 20 visits per benefit period combined for Acupuncture and Massage Therapy.</i>	0% coinsurance after deductible is met	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>	0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b>Preventive care / screenings / immunizations</b>	No charge	50% coinsurance after deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	50% coinsurance after deductible is met
<u><b>Diagnostic Services</b></u> <b>Lab</b> Office  Freestanding Lab  Outpatient Hospital	0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b>X-Ray</b> Office  Freestanding Radiology Center  Outpatient Hospital	0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i>  Office  Freestanding Radiology Center	0% coinsurance after deductible is met  0% coinsurance after deductible is met	50% coinsurance 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 a Non-Network Provider
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
<u><b>Emergency and Urgent Care</b></u> <b>Urgent Care</b> <b>Emergency Room Facility Services</b> <b>Emergency Room Doctor and Other Services</b> <b>Ambulance</b>	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	50% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u><b>Outpatient Mental Health and Substance Abuse Care at a Facility</b></u> Facility Fees  Doctor Services	0% coinsurance after deductible is met  0% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met
<u><b>Outpatient Surgery</b></u> <b>Facility Fees</b> Hospital  Ambulatory Surgical Center  <b>Doctor and Other Services</b> Hospital  Ambulatory Surgical Center	0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<u><b>Hospital (Including Maternity, Mental Health and Substance Abuse)</b></u>  <b>Facility Fees</b>  <b>Physician and other services</b> <i>including surgeon fees</i>	0% coinsurance after deductible is met  0% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	0% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i>  <i>Coverage for physical, speech, and occupational 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>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i></p>	<p>0% coinsurance after deductible is met</p>	<p>50% coinsurance after 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>0% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p><b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i></p>	<p>0% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p><b>Chemo/Radiation Therapy</b> <i>office and outpatient hospital</i></p>	<p>0% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p><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></p>	<p>0% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p><b>Inpatient Hospice</b></p>	<p>0% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p><b>Durable Medical Equipment</b></p>	<p>0% coinsurance after deductible is met</p>	<p>Not covered</p>
<p><b>Prosthetic Devices</b>  <i>Coverage for wigs is limited to 1 item after cancer treatment up to a \$500 maximum per member.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>Not covered</p>
<p><b>Hearing Aids</b>  <i>Coverage is limited to 1 item per ear every 5 years for members under 18 years of age.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
<b>Prescription Drug Coverage</b> <b>Network: <i>Base Network</i></b> <b>Drug List: <i>Essential Drugs not included on the Essential drug list will not be covered.</i></b>		
<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 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 CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). 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. Drug cost share assistance programs may be available for certain specialty drugs.		
Tier 1 - Typically Generic	0% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	0% coinsurance after deductible is met (retail and home delivery)	Not covered (retail and home delivery)
Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-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>		

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<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 representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- 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 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.*

Your Plan: Health Savings Account HSA Compatible PPO Plan 28E Essential Rx

Your Network: PPO

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

## 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 (877) 811-3106

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 (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:

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**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.

**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.

**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。

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(877) 811-3106로 문의하십시오.



## 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 bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninizingo kojí' hodíílnih (877) 811-3106.

**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: (877) 811-3106.

**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, (877) 811-3106 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. (877) 811-3106.

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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>.