Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: BlueClassic PPO 21 30/60/3000/6500/70% $15/50/75/30% Essential Tiered Rx

Your Network: PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$3,000 member / $9,000 family	$9,000 member / $27,000 family
Overall Out-of-Pocket Limit	$6,500 member / $13,000 family	$19,500 member / $39,000 family
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. Your copays, coinsurance and deductible count toward your out of pocket limit(s). In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at No charge.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at No charge.*		
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	**virtual-**No charge **office-**$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Specialist Care *virtual and office*	$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	$250 copay per pregnancy medical deductible does not apply	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$30 copay per visit medical deductible does not apply	Not covered
Chiropractic Services *Coverage is limited to 20 visits per benefit period.*	$30 copay per visit medical deductible does not apply	Not covered
Acupuncture *Coverage is limited to 20 visits per benefit period combined for Acupuncture and Massage Therapy.*	$30 copay per visit medical deductible does not apply	Not covered
Other Services in an Office		
Allergy Testing	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prescription Drugs *Dispensed in the office*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Surgery	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after medical deductible is met
Diagnostic Services **Lab**		
Office	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Lab	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray		
Office	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Radiology Center	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Freestanding Radiology Center	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$60 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Emergency Room Facility Services	30% coinsurance after medical deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	30% coinsurance after medical deductible is met	Covered as In-Network
Ambulance	30% coinsurance after medical deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor Services	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Outpatient Surgery **Facility Fees**		
Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Ambulatory Surgical Center	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Doctor and Other Services		
Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Ambulatory Surgical Center	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Hospital (Including Maternity, Mental Health and Substance Abuse)		
Facility Fees	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Physician and other services *including surgeon fees*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	30% coinsurance after medical deductible is met	Not covered
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *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.*		
Office	$30 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Inpatient Hospice	30% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Durable Medical Equipment	30% coinsurance after medical deductible is met	Not covered
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment up to a $500 maximum per member.*	30% coinsurance after medical deductible is met	Not covered
Hearing Aids *Coverage is limited to 1 item per ear every 5 years for members under 18 years of age.*	30% coinsurance after medical deductible is met	50% 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 a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable	Not covered

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage **Network:** ***Rx Choice Tiered Network*** **Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.*			
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *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.* **Specialty Pharmacy** *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	$15 copay per prescription (retail) and $37.50 copay per prescription (home delivery)	$25 copay per prescription (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand	$50 copay per prescription (retail) and $150 copay per prescription (home delivery)	$60 copay per prescription (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	$75 copay per prescription (retail) and $225 copay per prescription (home delivery)	$85 copay per prescription (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	30% coinsurance up to $350 per prescription (retail and home delivery)	30% coinsurance up to $500 per prescription (retail) and Not covered (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
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.		

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Children's Vision exam (up to age 19) *Limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision exam (age 19 and older) *Limited to 1 exam per benefit period.*	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.
- 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 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

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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

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(TTY/TDD: 711)

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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.

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