Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your 2022 Contract Code: 67FH

Your Plan: Anthem Silver PPO 4000/30%/8250 Rx Copay

Your Network: Anthem 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.*	$4,000 person / $8,000 family	$12,000 person / $24,000 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.*	$8,250 person / $16,500 family	$24,750 person / $49,500 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	50% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits)		
Virtual Visits with Doctors who also provide services in person		
Primary Care (PCP)	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Mental Health and Substance Abuse care	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups*	No charge	
Virtual Visits from Online Provider LiveHealth Online - *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	No charge	
Specialist Care	$80 copay per visit deductible does not apply	
Visits in an Office		
Primary Care (PCP)	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-Network preventive prenatal services are covered at 100%.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chiropractic *Coverage is limited to 20 visits per benefit period. Limit is combined across all settings.*	$30 copay per visit deductible does not apply	Not covered
Acupuncture	$40 copay per visit deductible does not apply	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Coverage is limited to 20 visits per benefit period combined for Acupuncture and Massage Therapy. Applies to In-Network. Limit is combined across all settings.		
Other Services in an Office		
Allergy Testing	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	$500 copay per surgery and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

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 deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans		
Office	$250 copay per service and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	$250 copay per service and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	$250 copay per service and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care (Office Setting)	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Emergency Room copay is waived if directly admitted to the hospital.*	$500 copay per visit and then 30% coinsurance after deductible is met	Covered as In-Network

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency Room Doctor and Other Services	30% coinsurance after deductible is met	Covered as In-Network
Ambulance (Air and Ground) *Non-emergency, Non-Network ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	30% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility visit		
Facility Fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	$500 copay per visit and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	$500 copay per visit and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Surgical Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Abuse) *If readmitted within 72 hours for the same diagnosis of the previous discharge, no additional facility copayment is required. If transferred between facilities, only one copayment will apply.*		
Facility fees (for example, room & board) *Rehabilitation services in an inpatient hospital or acute care facility are limited to 60 days combined per benefit period. Limit is combined In-Network and Non-Network.*	$500 copay per admission and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 28 hours per week. Limit is combined In-Network and Non-Network. Visit limit does not apply to Home Infusion Therapy or Home Dialysis. Limits are combined for home health care and private duty nursing.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy) *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all settings.*		
Office	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Habilitation services (for example, physical/speech/occupational therapy) *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all settings.*		
Office	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation		
Office	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 100 days per benefit period. Limit is combined In-Network and Non-Network.*	$500 copay per admission and then 30% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Inpatient Hospice	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Limit is combined In-Network and Non-Network. Coverage for hearing aids services is limited to 1 item per ear every 5 years. Covered for children under 18 years of age. Limit is combined In-Network and Non-Network across all settings.*	50% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

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 applicable
Pharmacy Out of Pocket Limit	Combined with In-Network medical out of pocket limit	Combined with In-Network medical out of pocket limit	Combined with Non-Network medical out of pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Select drug list appear below. Drugs not included on the Select drug list will not be covered. Your plan uses the Rx Choice Tiered Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*			
Home Delivery Pharmacy *Maintenance medications are available through IngenioRx 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.*			
Tier 1a - Typically Lower Cost Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	No charge (retail and home delivery)	$10 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 1b - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail) and $25 copay per prescription, deductible does not apply (home delivery)	$20 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$60 copay per prescription, deductible does not apply (retail) and $180 copay per	$70 copay per prescription, deductible does not apply (retail) and	50% coinsurance, deductible does not apply (retail) and Not covered (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 a Non-Network Pharmacy
	prescription, deductible does not apply (home delivery)	Not covered (home delivery)	
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$125 copay per prescription, deductible does not apply (retail) and $375 copay per prescription, deductible does not apply (home delivery)	$135 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	$500 copay per prescription, deductible does not apply (retail and home delivery)	$600 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Your summary of benefits

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. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Only children's vision services count towards your out of pocket limit.*		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	Not Applicable	Not Applicable
Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	No charge	0% coinsurance
Frames *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Single Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	$0 copayment up to plan's Maximum Allowed Amount
Bifocal Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	$0 copayment up to plan's Maximum Allowed Amount
Trifocal Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	$0 copayment up to plan's Maximum Allowed Amount
Elective contact lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Non-Elective Contact Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 19 and older)		
Adult Vision Deductible	Not Applicable	Not Applicable
Vision exam	$20 copay	Reimbursed Up to $30

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.		
Frames *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	$130 Allowance	Reimbursed Up to $45
Single Vision Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	Reimbursed Up to $25
Bifocal Vision Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	Reimbursed Up to $40
Trifocal Vision Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	$20 copay	Reimbursed Up to $55
Elective contact lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	$80 Allowance	Reimbursed Up to $60
Non-Elective Contact Lenses *Coverage for Eye Glass Lenses or Contact Lens In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods.*	No charge	Reimbursed Up to $210

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Only children's dental services count towards your out of pocket limit.*		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Coverage for In-Network Providers and Non-Network Providers is limited to 2 visits per 12 months.*	No charge	30% coinsurance deductible does not apply
Basic services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Major services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Combined with medical deductible
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Annual maximum	Not covered	Not covered

Your summary of benefits

Your plan also includes the following Healthy Support & Rewards features. *To see your rewards and additional information log into the Anthem website at anthem.com or call the customer service number on your member ID card.*		
Smart Rewards	Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.	Up to $200 per member per year
Gym Reimbursement	Subscriber, spouse, and dependents age 18 and over can get money back for using a gym. Fitness membership dues, up to $400, are covered if you're a member of this plan. Work out 50 times at a qualifying fitness center for each six-month period within your benefit plan year. Benefit plan year is the yearly period of coverage that starts at the effective date of coverage.	

Your summary of benefits

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 requires the selection of a Primary Care Physician (PCP). Choosing a PCP is an important decision. Call us at the number on your ID card and we'll help you pick a doctor.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- If services are rendered by a non-participating provider and your plan includes out of network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating provider's charge.
- *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.
- Coverage for Non-emergency ambulance service for Non-Network Providers is limited to $50,000 maximum benefit per occurrence.
- Initial purchase of any arm or leg prosthetic is subject to a maximum deductible equal to the Medicare Part B deductible ($183) as of January 1 of the member's policy year. Member only needs to satisfy the Part B Medicare deductible amount until they reach plan deductible, and no further deductible would be applicable. Initial purchase of any arm or leg prosthetic is subject to 20% coinsurance or plan coinsurance, whichever is less. Deductible and coinsurance applied will accumulate to plan deductible and out-of-pocket maximums. Any repair or replacement of any arm or leg prosthetic after initial purchase is subject to plan cost shares. Please see CRS 10-16-104(14) for further details.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Covered out-of-network Human Organ and Tissue Transplant services do not apply toward the out-of-pocket limit.
- Designated Participating Provider Program: Certain Providers are part of our Designated Participating Provider Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions. We publish a directory of Blue Priority PPO Designated Participating Providers (called Designated Participating Providers) and Participating Providers.
- Benefit period refers to both calendar year and plan year.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

Your summary of benefits

- This health plan includes an Employee Assistance Program (EAP) with Emotional Wellbeing Resources to support your emotional health and wellness with resources including one-on-one counseling by phone, in person and online, virtual visits through LiveHealth Online. Three visits are provided at no charge and 24/7, 365 days of support on the go.

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) 837-8536

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 8536-837 (855) .

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) 837-8536:

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) 837-8536。

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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 (855) 837-8536.

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) 837-8536.

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) 837-8536.

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) 837-8536 にお電話ください。

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Language Access Services:

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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) 837-8536.

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.