Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Blue Priority HMO 2

Your Network: Blue Priority HMO*

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 Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or 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.*	$2,000 member / $6,000 family	Not covered
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.*	$4,000 member / $10,000 family	Not covered
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness *Other cost shares may apply depending on services provided.*	$20 copay per visit deductible does not apply	Not covered
Specialist Care Visit *Other cost shares may apply depending on services provided.*	$60 copay per visit deductible does not apply	Not covered

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Prenatal and Post-natal Care	$200 copay for prenatal office visit/delivery	Not covered
Other Practitioner Visits:		
Retail Health Clinic	$20 copay per visit deductible does not apply	Not covered
On-line Visit *(www.livehealthonline.com)*	$20 copay per visit deductible does not apply	Not Applicable
Chiropractic Services *Coverage is limited to 20 visits per benefit period. Applies to In-Network. Limit is combined across professional visits and outpatient facilities.*	$25 copay per visit deductible does not apply	Not covered
Acupuncture *Coverage is limited to 20 visits per benefit period combined for Acupuncture and Massage Therapy. Applies to In-Network.*	$25 copay per visit deductible does not apply	Not covered
Other Services in an Office:		
Allergy Testing *Costs may vary by site of service.*	No charge	Not covered
Chemo/Radiation Therapy	20% coinsurance after deductible is met	Not covered
Hemodialysis	20% coinsurance after deductible is met	Not covered
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	No charge	Not covered

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services		
Lab:		
Office *Costs may vary by site of service.*	No charge	Not covered
Freestanding Lab *Costs may vary by site of service.*	No charge	Not covered
Outpatient Hospital *Costs may vary by site of service.*	$250 copay per visit and then 20% coinsurance after deductible is met	Not covered
X-Ray:		
Office *Costs may vary by site of service.*	$60 copay per visit deductible does not apply	Not covered
Freestanding Radiology Center *Costs may vary by site of service.*	$60 copay per visit deductible does not apply	Not covered
Outpatient Hospital *Costs may vary by site of service.*	$250 copay per visit and then 20% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office *Costs may vary by site of service.*	$250 copay per procedure deductible does not apply	Not covered
Freestanding Radiology Center *Costs may vary by site of service.*	$250 copay per procedure deductible does not apply	Not covered
Outpatient Hospital *Costs may vary by site of service.*	$250 copay per procedure and then 20% coinsurance	Not covered

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	after deductible is met	
Urgent Care		
Urgent Care (Office Setting) *Other cost shares may apply depending on services provided.*	$60 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Facility Services *ER copayment is waived if admitted.*	$250 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services *Other cost shares may apply depending on services provided.*	No charge	Covered as In-Network
Ambulance (Air and Ground)	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit and Online Visit	$20 copay per visit deductible does not apply	Not Applicable
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	Not covered
Doctor Services	20% coinsurance after deductible is met	Not covered

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Outpatient Surgery		
Facility Fees:		
Hospital	$250 copay per admission and then 20% coinsurance after deductible is met	Not covered
Freestanding Surgical Center	$250 copay per admission deductible does not apply	Not covered
Doctor and Other Services:		
Hospital *Costs may vary by site of service.*	20% coinsurance after deductible is met	Not covered
Freestanding Surgical Center *Costs may vary by site of service.*	No charge	Not covered
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Limited to 30 inpatient rehab days per calendar year.*	$250 copay per admission and then 20% coinsurance after deductible is met	Not covered
Doctor and other services	20% coinsurance after deductible is met	Not covered

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Recovery & Rehabilitation		
Home Health Care *Up to 100 visits per calendar year.*	20% coinsurance after deductible is met	Not covered
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Up to 20 visits each for physical, occupational or speech therapy per calendar year.*	$20 copay per visit deductible does not apply	Not covered
Outpatient Hospital *Office and outpatient visits count towards your rehabilitation limit.*	$20 copay per visit deductible does not apply	Not covered
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Habilitation visits count towards your rehabilitation limit.*	$20 copay per visit deductible does not apply	Not covered
Outpatient Hospital *Habilitation visits count towards your rehabilitation limit.*	$20 copay per visit deductible does not apply	Not covered
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period. Applies to In-Network.*	20% coinsurance after deductible is met	Not covered
Outpatient Hospital *Office and outpatient visits count towards your rehabilitation limit.*	20% coinsurance after deductible is met	Not covered
Skilled Nursing Care (in a facility) *Up to 100 days per calendar year.*	20% coinsurance after deductible is met	Not covered
Hospice	No charge	Not covered

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Durable Medical Equipment	50% coinsurance after deductible is met	Not covered
Prosthetic Devices	50% coinsurance after deductible is met	Not covered
Hearing Aids **Child Hearing Aids –** Hearing aids are covered up to age 18. Initial and replacement hearing aids will be supplied once every 5 years. *New hearing aids will be a covered service when alterations to your existing hearing aids cannot adequately meet your needs or be repaired.*	50% coinsurance after deductible is met	Not covered
Adult Hearing Aids – Initial and replacement hearing aids will be supplied once every 3 years to a maximum benefit of $4,000 In- and Out-of-Network combined.	50% coinsurance after deductible is met	Not covered

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	$200 person / $400 family	Not covered
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Not covered
Prescription Drug Coverage *This plan uses an 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.*	$15 copay per prescription, Pharmacy deductible does not apply (retail) and $15 copay per prescription, Pharmacy deductible does not apply (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.*	$40 copay per prescription after Pharmacy deductible is met (retail) and $80 copay per prescription after Pharmacy deductible is met (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*	$60 copay per prescription after Pharmacy deductible is met (retail) and $120	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
coinsurance on all tiers for retail fills that exceed 30 days. Specialty drug networks must be used for in-network coverage.	copay per prescription after Pharmacy deductible is met (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.*	30% coinsurance up to $250 per prescription, Pharmacy deductible does not apply (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 Drug List. The Drug List includes selected Generic and Brand Name Drugs. A list of the drugs that are covered on the 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.

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Curious to know what all this says? We would be too. Here's the English version:
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(TTY/TDD: 711)

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