Anthem

Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Colorado Higher Education Insurance Benefits Alliance Trust PRIME

Your Network: Blue Priority 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.*	$500 member / $1,000 family	$1,200 member / $2,400 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.*	$3,000 member / $6,000 family	$6,000 member / $12,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	No charge *(Except for covered preventive facility services, covered person pays $500 Copayment.)*
Doctor Home and Office Services		
Designated Participating Providers: *Other cost shares may apply depending on services provided.*	$10 copay per visit deductible does not apply	35% coinsurance after deductible is met
Participating Providers:	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Specialist Care Visit **Designated Participating Providers:** *Other cost shares may apply depending on services provided.*	$10 copay per visit deductible does not apply	35% 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
Participating Providers:	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Prenatal and Post-natal Care *Your doctor's charge for delivery are part of prenatal and postnatal care.*		
Designated Participating Providers:	$150 copay for prenatal care office visit/delivery from the Doctor	35% coinsurance after deductible is met
Participating Providers:	You pay 15% after Deductible for prenatal care office visit/delivery from the Doctor	35% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	15% coinsurance after deductible is met	Not covered
Preferred On-line Visit	$10 copay per visit deductible does not apply	Not covered
Chiropractic Services *Coverage is limited to 20 visits per benefit period. Applies to In-Network and Out-of-Network. Limit is combined across professional visits and outpatient facilities.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Massage Therapy *Up to 20 visits per calendar year combined for massage and acupuncture therapy, regardless of which type of Provider renders the therapy.*	15% coinsurance after deductible is met	Not covered
Acupuncture/Nerve Pathway Therapy		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
Up to 20 visits per calendar year combined for massage and acupuncture therapy, regardless of which type of Provider renders the therapy.	15% coinsurance after deductible is met	
Other Services in an Office:		
Allergy Testing		
Office *Costs may vary by site of service.*	10% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Hospital *Costs may vary by site of service.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Chemo/Radiation Therapy	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Hemodialysis	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office *Costs may vary by site of service.*	10% coinsurance after deductible is met	35% coinsurance after deductible is met
Freestanding Lab *Costs may vary by site of service.*	10% coinsurance after deductible is met	35% 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
Outpatient Hospital *Costs may vary by site of service.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
X-Ray:		
Office *Costs may vary by site of service.*	10% coinsurance after deductible is met	35% coinsurance after deductible is met
Freestanding Radiology Center *Costs may vary by site of service.*	10% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Hospital *Costs may vary by site of service.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office *Costs may vary by site of service.*	10% coinsurance after deductible is met	35% coinsurance after deductible is met
Freestanding Radiology Center *Costs may vary by site of service.*	10% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Hospital *Costs may vary by site of service.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care (Office Setting) *Other cost shares may apply depending on services provided.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Emergency Room Facility Services	15% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services *Other cost shares may apply depending on services provided.*	15% 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
Ambulance (Air and Ground)	15% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Facility visit:		
Facility Fees	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Doctor Services	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Freestanding Surgical Center	10% coinsurance after deductible is met	35% coinsurance after deductible is met
Doctor and Other Services:		
Hospital *Costs may vary by site of service.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Freestanding Surgical Center *Costs may vary by site of service.*	10% coinsurance after deductible is met	35% 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
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Limited to 30 non-acute inpatient days per calendar year in and out of network combined.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Doctor and other services *Bariatric surgery has a per occurrence maximum payment of $15,000 per member for services received from a designated facility or $1,500 for a facility that is not a designated facility. Total per occurrence maximum payment shall not exceed $15,000 per member for designated and non-designated facilities combined*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Up to 60 visits per calendar year In and Out of Network combined.*	No charge	35% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Up to 60 visits combined for physical, occupational and speech therapy per calendar year In and Out- of-Network combined.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Hospital *Office and outpatient visits count towards your rehabilitation limit.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Habilitation visits count towards your rehabilitation limit.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Hospital *Habilitation visits count towards your rehabilitation limit.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Cardiac rehabilitation		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Outpatient Hospital *Office and outpatient visits count towards your rehabilitation limit.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Limited to 60 days per calendar year combined in and out of network.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Hospice	No charge	35% coinsurance after deductible is met
Durable Medical Equipment	15% coinsurance after deductible is met	35% coinsurance after deductible is met
Prosthetic Devices	15% coinsurance after deductible is met	35% coinsurance after deductible is met
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.*	15% coinsurance after deductible is met	35% coinsurance after deductible is met
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.	15% coinsurance after deductible is met	35% coinsurance after deductible is met

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	Not applicable	Not covered
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Not covered
Prescription Drug Coverage *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.*	$10 copay per prescription (retail) and $10 copay per prescription (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 (retail) and $80 copay per prescription (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.*	$60 copay per prescription (retail) and $120 copay per prescription (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.*	Up to $125 per prescription (retail)	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 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.

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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 (800) 542-9402

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 (800) 542-9402 .

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՝ (800) 542-9402:

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(800) 542-9402。

Farsi (فارسی) : در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (800) 542-9402 تماس بگیرید.

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 (800) 542-9402.

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 (800) 542-9402.

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 (800) 542-9402.

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、(800) 542-9402 にお電話ください。

Language Access Services:

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(800) 542-9402로 문의하십시오.

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (800) 542-9402.

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: (800) 542-9402.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (800) 542-9402 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. (800) 542-9402.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (800) 542-9402.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (800) 542-9402.

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 (800) 542-9402.

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.