Anthem

Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Colorado Higher Education Insurance Benefits Alliance Trust BlueAdvantage Point-of-Service (POS) Plan

Your Network: 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.*	$0 member / $0 family	$500 member / $1,000 family aggregate
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.*	$2,000 member / $4,000 family	$3,000 member / $6,000 family
Preventive care/screening/immunization *Covered preventive care services include those that meet the requirements of the law including certain screenings, immunizations and office visits; and are not subject to Coinsurance or Deductible.*	No charge	$30 copay per visit *Copayment includes services provided as preventive care. For covered preventive facility services, You pay $500 copayment.*
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	30% coinsurance after deductible
Specialist Care Visit *Other cost shares may apply depending on services provided.*	$40 copay per visit	30% coinsurance after deductible

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Prenatal and Post-natal Care *Your doctor's charge for delivery are part of prenatal and postnatal care.*	$20 copay for first office visit/delivery	30% coinsurance after deductible
Other Practitioner Visits:		
Retail Health Clinic	$20 copay per visit	Not covered
On-line Visit (*www.livehealthonline.com*)	$20 copay per visit	Not Applicable
Chiropractic Services *Coverage is limited to 20 visits per benefit period. Applies to In-Network and Out-of-Network combined. Visit limits are combined both across outpatient and other professional visits.*	$20 copay per visit	30% coinsurance after deductible
Acupuncture *Coverage is limited to 20 visits per benefit period combined for Acupuncture and Massage Therapy. Applies to In-Network.*	$20 copay per visit	Not covered
Other Services in an Office:		
Allergy Testing *Costs may vary by site of service.*	No charge	30% coinsurance after deductible
Chemo/Radiation Therapy	No charge	30% coinsurance after deductible
Hemodialysis	No charge	30% coinsurance after deductible
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	No charge	Not covered
Diagnostic Services		
Lab:		
Office	No charge	30% coinsurance after deductible
Freestanding Lab	No charge	30% coinsurance after deductible

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Outpatient Hospital	No charge	30% coinsurance after deductible
X-Ray:		
Office	No charge	30% coinsurance after deductible
Freestanding Radiology Center	No charge	30% coinsurance after deductible
Outpatient Hospital	No charge	30% coinsurance after deductible
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office *Costs may vary by site of service.*	$60 copay per procedure	30% coinsurance after deductible
Freestanding Radiology Center *Costs may vary by site of service.*	$60 copay per procedure	30% coinsurance after deductible
Outpatient Hospital *Costs may vary by site of service.*	$120 copay per procedure	30% coinsurance after deductible
Urgent Care		
Urgent Care (Office Setting) *Other cost shares may apply depending on services provided.*	$50 copay per visit	Covered as In-Network
Emergency Room Facility Services *Copayment is waived if admitted. Care is covered In or Out-of- Network.*	$150 copay per visit	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)	$100 copay per trip	Covered as In-Network

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Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit and Online Visit	$20 copay per visit	30% coinsurance after deductible
Facility visit:		
Facility Fees	No charge	30% coinsurance after deductible
Doctor Services	No charge	30% coinsurance after deductible
Outpatient Surgery		
Facility Fees:		
Hospital	$125 copay per date of service	30% coinsurance after deductible
Freestanding Surgical Center	$60 copay per date of service	30% coinsurance after deductible
Doctor and Other Services:		
Hospital *Costs may vary by site of service.*	No charge	30% coinsurance after deductible
Freestanding Surgical Center *Costs may vary by site of service.*	No charge	30% coinsurance after deductible
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.*	$600 copay per admission	30% coinsurance after deductible
Doctor and other services *Bariatric surgery has a per occurrence maximum payment of $15,000 per member for services received from a designated facility (and $1,500 per member from a facility that is not a designated facility) with a total per*	No charge	30% coinsurance after deductible

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
occurrence maximum that shall not exceed $15,000 per member for designated and non-designated facilities combined.		
Recovery & Rehabilitation **Home Health Care**	No charge	30% coinsurance after deductible
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Limited to 30 visits per calendar year each for physical, occupational and speech therapy in and out-of-network combined.*	$40 copay per visit	30% coinsurance after deductible
Outpatient Hospital *Office and outpatient visits count towards your rehabilitation limit.*	$40 copay per visit	30% coinsurance after deductible
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Habilitation visits count towards your rehabilitation limit.*	$40 copay per visit	30% coinsurance after deductible
Outpatient Hospital *Habilitation visits count towards your rehabilitation limit.*	$40 copay per visit	30% coinsurance after deductible
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period. Applies to In-Network and Out-of-Network combined.*	No charge	30% coinsurance after deductible
Outpatient Hospital *Office and outpatient visits count towards your rehabilitation limit.*	No charge	30% coinsurance after deductible
Skilled Nursing Care (in a facility) *Limited to 60 days per calendar year combined in and out of network.*	No charge	30% coinsurance after deductible
Hospice	No charge	30% coinsurance after deductible

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Durable Medical Equipment	No charge	30% coinsurance after deductible
Prosthetic Devices	No charge	30% coinsurance after deductible
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.*	No charge	30% coinsurance after deductible
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.	No charge	30% coinsurance after deductible

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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	Not applicable	Not covered
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Not covered
Prescription Drug Coverage *This plan uses a 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.*	$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.*	30% coinsurance up to $125 per prescription (retail and home delivery)	Not covered (retail and home delivery)

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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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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:

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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): Dii naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjį bee nił hodoonih t'áadoo bááh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (800) 542-9402.

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