El Paso County

2025 Summary of Benefits

PPO Coinsurance Plan 4PD

About this Plan:

Anthem Blue Cross and Blue Shield gives you the tools and resources to make the best decisions for your health, like this summary of benefits. It's a snapshot of your plan's covered benefits and services and what they cost. This Summary of Benefits doesn't list every service we cover or every limitation or exclusion. For more details about your benefits and services, please review your *Evidence of Coverage* (EOC). You can access your EOC online by logging into the member portal at **www.anthem.com**, or you can call Member Services with any questions you may have.

Doctor and hospital choice: You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.

This plan offers coverage in our Centers for Medicare & Medicaid Services (CMS) defined geographic service area of all 50 states, Washington, DC, and all United States territories.

How much is the monthly premium?:
Contact your group plan benefit administrator to determine your actual premium amount, if applicable.

Questions?

Call our **Member Services Team** for answers or plan details and provide them with this group specific code .

Prospective Members, please contact your benefit administrator. When you enroll in the plan you will receive information that tells you where to go online to view your *Evidence of Coverage*.

Anthem Medicare Preferred (PPO) Benefits Effective: 01/01/2025 – 12/31/2025

Plan Features	In-network:	Out-of-network:
Annual medical deductible:	$250 combined in-network and out-of-network	
Maximum out-of-pocket responsibility: (Does not include Part D prescription drugs)	$2,250 combined in-network and out-of-network	

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Inpatient hospital care* No limit to the number of days covered by the plan	$0 copay per admission	$0 copay per admission
Outpatient hospital facility or ambulatory surgical center visit for surgery*	4% coinsurance per visit	4% coinsurance per visit
Outpatient hospital services observation room	4% coinsurance per visit	4% coinsurance per visit
Primary care office visit	4% coinsurance per visit	4% coinsurance per visit
Specialty care office visit	4% coinsurance per visit	4% coinsurance per visit
Preventive care, screenings, and tests	$0 copay per visit	$0 copay per visit
Emergency care	$0 copay per visit	
Urgently needed services	$65 copay per visit $65 copay is waived if the member is admitted to the hospital within 72 hours for the same condition.	
X-ray visit and/or simple diagnostic test*	4% coinsurance per visit	4% coinsurance per visit
Complex diagnostic test and/or radiology visit*	4% coinsurance per visit	4% coinsurance per visit
Radiation therapy treatment*	4% coinsurance per visit	4% coinsurance per visit
Clinical/diagnostic lab test*	$0 copay per visit	$0 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Medicare-covered basic hearing and balance exams performed by your specialist*	4% coinsurance per visit	4% coinsurance per visit
Medicare-covered dental is non-routine care performed by your specialist*	4% coinsurance per visit	4% coinsurance per visit
Medicare-covered exams performed by your specialist to diagnose and treat eye diseases and conditions	4% coinsurance per visit	4% coinsurance per visit
Medicare-covered glaucoma screening	$0 copay per visit	$0 copay per visit
Medicare-covered eyewear following cataract surgery	4% coinsurance per surgery	4% coinsurance per surgery
Routine vision services	Must use a Blue View Vision provider. **Exams** $0 copay for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $0 copay for eyewear $100 maximum benefit every two calendar years combined in-network and out-of-network	**Exams** $70 reimbursement for routine vision exams 1 exam every calendar year combined in-network and out-of-network **Eyewear** $100 reimbursement for eyewear, maximum benefit every two calendar years combined in-network and out-of-network
Inpatient services in a psychiatric hospital* No limit to the number of days covered by the plan	$0 copay per admission 190 days limit per lifetime for inpatient mental health care in a freestanding psychiatric hospital combined in-network and out-of-network. Does not apply to inpatient mental health care provided in a general hospital.	$0 copay per admission 190 days limit per lifetime for inpatient mental health care in a freestanding psychiatric hospital combined in-network and out-of-network. Does not apply to inpatient mental health care provided in a general hospital.

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Mental health professional individual therapy visit	4% coinsurance per visit	4% coinsurance per visit
Substance use disorder professional individual therapy visit	4% coinsurance per visit	4% coinsurance per visit
Skilled nursing facility (SNF) care*	$0 copay for days 1-100 per benefit period 100-day limit per benefit period	$0 copay for days 1-100 per benefit period 100-day limit per benefit period
Outpatient rehabilitation services*	4% coinsurance per visit	4% coinsurance per visit
Ambulance services	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. 4% coinsurance per one-way trip for ambulance services	
Routine Transportation Non-Emergency	$0 copay for routine transportation 12 one-way trips each year	
Medicare Part B prescription drugs*	$0 copay for Part B drugs	$0 copay for Part B drugs
Chiropractic services* Medicare-covered	4% coinsurance per visit	4% coinsurance per visit
Acupuncture for chronic low back pain* Medicare-covered	4% coinsurance per visit	4% coinsurance per visit
Additional acupuncture services*	4% coinsurance per visit 20 visits per year combined in-network and out-of-network for additional acupuncture services	4% coinsurance per visit 20 visits per year combined in-network and out-of-network for additional acupuncture services
Cardiac rehabilitation services*	$0 copay per visit	$0 copay per visit
Pulmonary rehabilitation services*	4% coinsurance per visit	4% coinsurance per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Blood glucose test strips, lancets, lancet devices, and glucose control solutions For a 30 day supply	**If purchased through a pharmacy:** $0 copay per purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) $10 for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) $10 for all other brands when purchased through the pharmacy
Blood glucose monitors	**If purchased through a pharmacy:** $0 copay per purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) $10 for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay per purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) $10 for all other brands when purchased through the pharmacy
Therapeutic shoes	$0 copay per purchase	$0 copay per purchase
Diabetes self-management training	$0 copay per visit	$0 copay per visit
Continuous glucose monitors (CGMs)*	$0 copay per purchase	$0 copay per purchase
Durable medical equipment (DME) and related supplies*	4% coinsurance per purchase	4% coinsurance per purchase
Opioid treatment program services*	4% coinsurance per visit	4% coinsurance per visit
Podiatry services*	4% coinsurance per visit	4% coinsurance per visit
Routine foot care	4% coinsurance per visit 12 visits per year combined in-network and out-of-network	4% coinsurance per visit 12 visits per year combined in-network and out-of-network
Home health agency care*	$0 copay per visit	$0 copay per visit

Covered benefits	In-network, members pay:	Out-of-network, members pay:
Hospice care When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan.	4% coinsurance for the one time only consultation 1 visit per lifetime	4% coinsurance for the one time only consultation 1 visit per lifetime

Additional covered benefits and services	Member pays unless specified:
Video doctor visits LiveHealth Online†	$0 copay for video doctor visits using LiveHealth Online
Health and wellness programs **SilverSneakers® Membership†** Take fitness classes virtually or visit a participating location.	$0 copay for the SilverSneakers fitness benefit
24/7 NurseLine†	$0 copay for 24/7 NurseLine
Foreign travel emergency (outside U.S. territories) **Emergency care** Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Deductible** $100 per year for all foreign travel emergency, urgently needed care services, or inpatient care **Emergency care** 20% coinsurance for emergency care
Foreign Travel - Urgently Needed Services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Deductible** $100 per year for all foreign travel emergency, urgently needed care services, or inpatient care **Urgently needed services** 20% coinsurance for urgently needed services
Foreign Travel - Inpatient Care Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months	**Deductible** $100 per year for all foreign travel emergency, urgently needed care services, or inpatient care **Inpatient care** 20% coinsurance per admission 60 days per lifetime **Maximum Benefit** $25,000 maximum benefit per year for all foreign travel emergency care, urgently needed care services, or inpatient care
Healthy Meals†§* Meals delivered after being discharged from inpatient hospital visit or for members living with a chronic condition	$0 copay for Healthy Meals 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total).

Additional covered benefits and services	Member pays unless specified:
Personal home helper* Caregiver must meet all applicable state licensing/certification requirements to be eligible for reimbursement.	$0 copay for personal home helper services, covers up to 124 hours of care per year (up to four hours per day for a maximum of 31 days in the year), reimburse up to a $100 maximum benefit per day
Medicare Community Resource Support	$0 copay for Medicare Community Resource Support

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the benefits chart.

This document reflects cost shares only.

†Must use the plan approved provider

§ The benefits mentioned are Special Supplemental Benefits for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in the plan's Evidence of Coverage.

Some of the benefits and limitations listed above are combined in-network and out-of-network.

This information is not a complete description of the benefits. Contact the plan for more information. Limitations, copayments, coinsurance, and restrictions may apply. If there is a difference between this document and the *Evidence of Coverage* (EOC), the EOC is considered correct.

Benefits, premiums and/or copayments/coinsurance may change upon renewal or on January 1 of each year.

Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our member service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service.

Medicare & You 2025 resource: For more information, we encourage you to read Medicare & You 2025. This booklet is mailed to people with Medicare every year in the fall. It has a summary of Medicare

benefits, rights, and protections. It also includes answers to the most frequently asked questions. If you don't have a copy of this booklet, request one at **www.medicare.gov.** Or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**.

LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan.