

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: \$1,500 PPO Plan

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$1,500 person / \$3,000 family	\$4,500 person / \$9,000 family
Out-of-Pocket Limit	\$4,000 person / \$8,000 family	\$9,000 person / \$18,000 family
<p>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.</p>		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
<p><u>Doctor Home and Office Services</u></p> <p>Primary Care Visit <i>When Allergy injections are billed separately by network providers, the member is responsible for a \$5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.</i></p>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Specialist Care Visit <i>When Allergy injections are billed separately by network providers, the member is responsible for a \$5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.</i></p>	\$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prenatal and Post-natal Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><u>Other Practitioner Visits:</u></p> <p>Retail Health Clinic</p> <p>On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy <i>Coverage is limited to 25 visits per benefit period.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Other Services in an Office:</u> Allergy Testing & Serum Chemo/Radiation Therapy - PCP Chemo/Radiation Therapy - Specialist Dialysis/Hemodialysis Prescription Drugs - <i>Dispensed in the office</i>	No charge 20% coinsurance after deductible is met \$50 copay per visit deductible does not apply \$50 copay per visit deductible does not apply 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab: Office Freestanding Lab/Reference Lab Outpatient Hospital	No charge No charge 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
X-Ray: Office Outpatient Hospital	No charge 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Advanced Diagnostic Imaging: Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care <i>When Allergy injections are billed separately by network providers, the member is responsible for a \$5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.</i></p>	\$95 copay per visit deductible does not apply	50% coinsurance after deductible is met
<p>Emergency Room Facility Services <i>Copay waived if admitted.</i></p>	\$500 copay per visit deductible does not apply	Covered as In-Network
<p>Emergency Room Doctor and Other Services</p>	No charge	Covered as In-Network
<p><u>Ambulance</u></p>	20% coinsurance after deductible is met	Covered as In-Network
<p><u>Outpatient Mental/Behavioral Health and Substance Abuse</u></p> <p>Doctor Office Visit</p> <p>Facility visit:</p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Doctor and Other Services:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></p> <p>Facility fees</p> <p>Human Organ and Tissue Transplants <i>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i></p> <p>Doctor and other services</p>	<p>20% coinsurance after deductible is met</p> <p>No charge</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Rehabilitation services:</p> <p>Office <i>Coverage for rehabilitative and habilitative physical therapy, occupational, speech therapy, and cardiac rehabilitation have a combined limit of 60 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage for rehabilitative and habilitative physical therapy, occupational, speech therapy, and cardiac rehabilitation have a combined limit of 60 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation</p> <p>Office <i>Coverage for rehabilitative and habilitative physical therapy, occupational, speech therapy, and cardiac rehabilitation have a combined limit of 60 visits per benefit period.</i></p> <p>Outpatient Hospital</p>	<p>\$50 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>Coverage for rehabilitative and habilitative physical therapy, occupational, speech therapy, and cardiac rehabilitation have a combined limit of 60 visits per benefit period.</i>		
Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing is limited to 60 days per benefit period.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	No charge	No charge
Durable Medical Equipment	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits National Drug List National Network w/R90 and Optional Home Delivery	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with In-Network medical	Combined with Non-Network medical
Tier 1 - Typically Generic <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$10 copay per prescription, deductible does not apply (retail) and \$25 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$40 copay per prescription, deductible does not apply (retail) and \$100 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits National Drug List National Network w/R90 and Optional Home Delivery	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 3 - Typically Non-Preferred Brand <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$70 copay per prescription, deductible does not apply (retail) and \$175 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) <i>30 day supply (retail pharmacy). 30 day supply (home delivery).</i>	25% coinsurance per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services” which is generally coinsurance or coinsurance after your deductible is met.
- If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit or outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.

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.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

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 (833) 578-4443

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 (833) 578-4443.

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՝ (833) 578-4443:

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(833) 578-4443。

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 (833) 578-4443 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 (833) 578-4443.

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 (833) 578-4443.

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 (833) 578-4443.

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、(833) 578-4443 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 (833) 578-4443로 문의하십시오.

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninízingo koj̄' hodiilnih (833) 578-4443.

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: (833) 578-4443.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 578-4443 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. (833) 578-4443.

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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 (833) 578-4443.

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 (833) 578-4443.

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>.