

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: BlueSecure PPO 8 Blue Priority \$30/\$2500/80% 15/45/75/30% Essential Tiered Rx

Your Network: Blue Priority PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge deductible does not apply
Mental Health & Substance Use Disorder Services	No charge deductible does not apply
Specialist care	\$60 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$2,500 member / \$7,500 family	\$5,000 member / \$15,000 family
Overall Out-of-Pocket Limit	\$6,350 member / \$12,700 family	\$19,050 member / \$38,100 family
<p>The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per member deductible or per member out-of-pocket limit.</p> <p>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.</p> <p>In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	\$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	\$200 copay per pregnancy deductible does not apply	50% coinsurance after deductible is met
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Spinal Manipulation <i>Coverage is limited to 20 visits per benefit period.</i>	\$30 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Acupuncture <i>Coverage is limited to 20 visits per benefit period.</i>	\$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs <i>Dispensed in the office</i> Surgery	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	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 Freestanding Radiology Center Outpatient Hospital	\$30 copay per visit deductible does not apply \$30 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
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% 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 an Out-of-Network Provider
<u>Emergency and Urgent Care</u> Urgent Care includes doctor services. Additional charges may apply depending on the care provided. There may be other levels of cost share that are contingent on how services are provided. Emergency Room Facility Services Your copay will be waived if admitted. Emergency Room Doctor and Other Services There may be other levels of cost share that are contingent on how services are provided. Ambulance Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.	\$60 copay per visit deductible does not apply \$300 copay per visit and 20% coinsurance deductible does not apply 20% coinsurance deductible does not apply 20% coinsurance after deductible is met	50% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u> Facility Fees Doctor Services	 20% coinsurance after deductible is met 20% coinsurance after deductible is met	 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services including surgeon fees Hospital Ambulatory Surgical Center	 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 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
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> Facility Fees Physician and other services including surgeon fees	 20% coinsurance after deductible is met 20% coinsurance after deductible is met	 50% coinsurance after deductible is met 50% coinsurance after deductible is met
Home Health Care Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.	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 an Out-of-Network Provider
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is limited to 40 visits combined per benefit period. Coverage for speech therapy is limited to 20 visits per benefit period. Costs may vary by site of service. Office and outpatient visits count towards your rehabilitation limit.</i> Office Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Pulmonary rehabilitation <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment up to a \$500 maximum per member.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage Network: Rx Choice Tiered Network Drug List: Essential Drugs <i>not included on the Essential drug list will not be covered.</i>			
Day Supply Limits: Retail Pharmacy 30 day supply (cost shares noted below) Retail 90 Pharmacy 90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network)			

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<p><i>Retail Pharmacies noted below applies).</i></p> <p>Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You may get two 30-day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must call us on the number on your ID card and tell us if you would like to keep getting your maintenance medications from a retail pharmacy or if you would like to use home delivery. If you do not contact us, you will pay the full retail cost of any maintenance medication until you inform us of your decision.</p> <p>Specialty Pharmacy 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.</p>			
Tier 1 - Typically Generic	\$15 copay per prescription (retail) and \$37.50 copay per prescription (home delivery)	\$25 copay per prescription (retail only)	50% coinsurance (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	\$45 copay per prescription (retail) and \$112.50 copay per prescription (home delivery)	\$55 copay per prescription (retail only)	50% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$75 copay per prescription (retail) and \$225 copay per prescription (home delivery)	\$85 copay per prescription (retail only)	50% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic)	30% coinsurance up to \$500 per prescription (retail and home delivery)	30% coinsurance up to \$600 per prescription (retail only)	50% coinsurance (retail) and Not covered (home delivery)

Notes:

- The Primary Care Physician and Specialist office visit cost share applies to both office and facility based office visits for evaluation and management services only.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.

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.

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Questions: (877) 811-3106 or visit us at www.anthem.com

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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

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document

Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인 이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòm nan dokiman sa a.

Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Դարգապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください。視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>