Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: BlueSecure PPO $35/$3500/80% 15/40/60/20% Essential Tiered Rx

Your Network: 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	$3,500 member / $7,000 family	$7,000 member / $14,000 family
Overall Out-of-Pocket Limit	$6,600 member / $13,200 family	$13,000 member / $26,000 family
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. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit. In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care *virtual and office*	$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)	No charge	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
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Spinal Manipulation *Coverage is limited to 20 visits per benefit period.*	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Services in an Office		
Allergy Testing	$35 copay deductible does not apply	50% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	$35 copay deductible does not apply	50% coinsurance after deductible is met
Surgery	$35 copay deductible does not apply	50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	50% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	$35 copay deductible does not apply	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	$35 copay deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	$35 copay deductible does not apply	50% coinsurance after deductible is met
X-Ray Office	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Freestanding Radiology Center	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met

Outpatient Hospital	$60 copay 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
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	$300 copay deductible does not apply	50% coinsurance after deductible is met
Freestanding Radiology Center	$300 copay deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	$300 copay deductible does not apply	50% coinsurance after deductible is met
Emergency and Urgent Care		
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.*	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	$350 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services *There may be other levels of cost share that are contingent on how services are provided.*	No charge	Covered as In-Network
Ambulance *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	$200 copay deductible does not apply	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	$35 copay deductible does not apply	50% coinsurance after deductible is met
Doctor Services	$35 copay deductible does not apply	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and other services *including surgeon fees*		

Hospital	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
Ambulatory Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Home Health Care *Coverage is limited to 120 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice Care-Inpatient & Outpatient	$35 copay deductible does not apply	50% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *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.*		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	No charge	50% coinsurance after deductible is met
Habilitative Physical, Occupational & Speech Therapy	No charge	50% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	$35 copay deductible does not apply	50% coinsurance after deductible is met

Cardiac rehabilitation *office and outpatient hospital* *Coverage is limited to 36 visits per benefit period.*	$35 copay deductible does not apply	50% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	$35 copay deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	$35 copay deductible does not apply	50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient & Outpatient Hospice	$35 copay deductible does not apply	50% coinsurance after deductible is met
Durable Medical Equipment	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
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment up to a $500 maximum per member.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a In-Network Pharmacy		Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Not applicable		Not applicable
Pharmacy 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: Base Network** **Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.*			

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 In-Network Retail Pharmacies noted below applies).*
Home Delivery Pharmacy *90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy.* **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.*

Tier 1 - Typically Generic	$15 copay per prescription (retail) and $30 copay per prescription (home delivery)		20% coinsurance (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	$40 copay per prescription (retail) and $80 copay per prescription (home delivery)		20% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	$60 copay per prescription (retail) and $120 copay per prescription (home delivery)		20% coinsurance (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	**Cost if you use a In- Network Pharmacy**		**Cost if you use an Out-of-Network Pharmacy**
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance up to $500 per prescription (retail and home delivery)		20% 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.
- 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.

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

Your summary of benefits

Anthem

Your Plan: BlueSecure PPO 8 $35/$3500/80% 15/40/60/20% Essential Tiered Rx
Your Network: PPO

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

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 (877) 811-3106

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 (877) 811-3106.

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՝ (877) 811-3106:

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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 (877) 811-3106.

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 (877) 811-3106.

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 (877) 811-3106.

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、(877) 811-3106 にお電話ください。

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Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bąąh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih ninízingo kojį' hodíílnih (877) 811-3106.

Language Access Services:

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: (877) 811-3106.

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It's important we treat you fairly

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