

Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Anthem Blue Access Choice PPO HSA (with Copay) Option E3 with Rx Option C4

Your Network: Blue Access Choice

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 has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible <i>See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.</i>	\$5,000 person / \$10,000 family	\$15,000 person / \$30,000 family
Out-of-Pocket Limit <i>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.</i>	\$6,900 person / \$13,800 family	\$20,700 person / \$41,400 family
Preventive care/screening/immunization <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services Primary Care Visit to treat an injury or illness <i>When Allergy injections are billed separately by network providers, the member is responsible for \$10 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.</i>	\$25 copay per visit after deductible is met	30% coinsurance after deductible is met

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<p>Specialist Care Visit <i>When Allergy injections are billed separately by network providers, the member is responsible for \$10 copay after deductible is met. 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 after deductible is met	30% coinsurance after deductible is met
<p>Prenatal and Post-natal Care <i>In-Network preventive prenatal services are covered at 100%.</i></p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p>Other Practitioner Visits:</p> <p>Retail Health Clinic</p> <p>Preferred On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i></p> <p>Other Participating Provider On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i></p> <p>Manipulation Therapy <i>Coverage is limited to 26 visits per benefit period. Applies to In-Network. Limit is combined across professional visits and outpatient facilities.</i></p>	<p>\$25 copay per visit after deductible is met</p> <p>\$10 copay per visit after deductible is met</p> <p>\$25 copay per visit after deductible is met</p> <p>50% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>Not covered</p>
<p>Other Services in an Office:</p> <p>Allergy Testing</p> <p>Chemo/Radiation Therapy Performed by a Primary Care Physician</p> <p>Chemo/Radiation Therapy Performed by a Specialist</p>	<p>0% coinsurance after deductible is met</p> <p>\$25 copay per visit after deductible is met</p> <p>\$50 copay per visit after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

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Dialysis/Hemodialysis	\$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Prescription Drugs <i>For the drugs itself dispensed in the office through infusion/injection.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met

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<p>Emergency and Urgent Care</p> <p>Urgent Care <i>Member cost share for Allergy injections billed separately is \$10 copay after deductible. If billed with an Urgent Care Facility charge, it will be covered under the UC copayment, there is no additional cost to the member for injection. The urgent care office visit cost share applies to both office and facility based urgent care providers.</i></p>	<p>\$75 copay per visit after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Emergency Room Facility Services <i>Copay waived if admitted.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Emergency Room Mental/Behavioral Health and Substance Abuse Doctor Services</p>	<p>\$300 copay per visit after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>\$25 copay per visit after deductible is met</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p>Ambulance (Air, Ground, and Water) <i>Non-emergency non-network Ambulance Services are limited to \$50,000 per occurrence.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>Covered as In-Network</p>
<p>Outpatient Mental/Behavioral Health and Substance Abuse</p> <p>Doctor Office Visit</p> <p>Facility visit:</p> <p style="padding-left: 20px;">Facility Fees</p> <p style="padding-left: 20px;">Doctor Services</p>	<p>\$25 copay per visit after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

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<p>Outpatient Surgery</p> <p>Facility Fees:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)</p> <p>Facility fees (for example, room & board) <i>Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period. Benefit includes coverage for Outpatient Rehabilitation program.</i></p> <p>Human Organ and Tissue Transplants <i>Acquisition and transplant procedures, collection and storage. 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>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

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<p>Recovery & Rehabilitation</p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.</i></p>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p>Rehabilitation services (for example, physical/speech/occupational therapy):</p> <p>Office <i>Coverage for Occupational Rehabilitation services is limited to 20 visits per benefit period. Coverage for Physical Rehabilitation and Manipulation Therapy services is limited to 20 visits per benefit period. Limit does not apply to manipulation performed by a Chiropractor. Limit is combined In-network and Non-Network across professional and outpatient visits. Speech Therapy has no visit limit. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.</i></p> <p>Outpatient Hospital <i>Coverage for Occupational Rehabilitation services is limited to 20 visits per benefit period. Coverage for Physical Rehabilitation and Manipulation Therapy services is limited to 20 visits per benefit period. Limit does not apply to manipulation performed by a Chiropractor. Limit is combined In-network and Non-Network across professional and outpatient visits. Speech Therapy has no visit limit. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.</i></p>	<p>\$25 copay per visit after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation</p> <p>Office <i>Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.</i></p> <p>Outpatient Hospital <i>Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.</i></p>	<p>\$50 copay per visit after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Pulmonary rehabilitation</p> <p>Office <i>Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.</i></p> <p>Outpatient Hospital <i>Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.</i></p>	<p>\$50 copay per visit after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (in a facility) <i>Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Hospice</p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Durable Medical Equipment</p>	<p>50% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Prosthetic Devices <i>Coverage for wigs after cancer treatment is limited to 1 item per benefit period. Coverage for wigs needed after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network. Applies to In-Network.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>

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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	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage <i>Essential Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</i>		
Tier 1 - Typically Generic <i>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.</i>	\$15 copay per prescription after deductible is met (retail) and \$38 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand <i>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.</i>	\$40 copay per prescription after deductible is met (retail) and \$120 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand <i>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.</i>	\$80 copay per prescription after deductible is met (retail) and \$240 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Tier 4 - Typically Specialty (brand and generic) <i>Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.</i></p>	25% coinsurance up to \$350 per prescription after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (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.
- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent age: to end of the month in which the child attains age 26.
- 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.
- Certain diabetic and asthmatic supplies are available at Network pharmacies, diabetic test strips paid same as any other drug.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- 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 (HOTI) Services).
- Certain diabetic and asthmatic supplies are covered subject to applicable prescription drug copayments/coinsurance when you get them from an In network pharmacy. These supplies are covered as medical supplies and durable medical equipment if you get them from an Out of network pharmacy. Diabetic test strips are covered subject to applicable prescription drug copayment/coinsurance. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- DME - 50% coinsurance for Network/Non-Network Durable Medical Equipment, Medical Supplies, Orthotics, Asthma Supplies, and Phenylketonuria (PKU). Excludes Prosthetics, Wigs, Diabetic Supplies and Mastectomy prostheses which will apply the plan's cost shares.
- Hospital stay for Maternity Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- The Rx option includes the Essential formulary which is a closed drug list with a focus on therapeutic efficacy and cost effectiveness.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice. Specialist (SCP) copayment is applicable to all Specialists (excludes: General

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Physicians, Internists, Pediatricians, OB/Gyns, Geriatrics, Physical Therapy, Occupational Therapy or any other Network provider as allowed by the plan).

- Immunization through age 5 – No Cost Share up to the maximum allowable amount (Network/Non-Network).
- Benefits are limited to abortions performed to preserve the life of the female upon whom the abortion is performed. Elective abortions are not a Covered Service.
- Urgent Care Facility Copay exclude certain diagnostic test such as MRAs, MRIs, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, Allergy Testing, and Pharmaceutical injection and drugs.
- 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.

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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

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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) 578-4436

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) 578-4436.

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) 578-4436:

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Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'ídiłkidgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee nił hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'į' hadeesdzih ninizingo kojį' hodíłłnih (833) 578-4436.

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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 ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 578-4436 ਤੇ ਕਾਲ ਕਰੋ।

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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) 578-4436.

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>.