Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Contract Code: 6B10

Your Plan: CBP MEWA Blue Access Choice PPO 2000/0%/4000 Plan 3

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 Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$2,000 person / $4,000 family	$4,000 person / $12,000 family
Out-of-Pocket Limit *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.*	$4,000 person / $8,000 family	$8,000 person / $24,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Immunizations for children prior to their 6th birthday have No Cost Share for In-Network and Non-Network Charges. This applies to childhood immunizations only, not other preventive care.* **Preventive Care for Chronic Conditions** *per IRS guidelines*	No charge No charge	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Virtual Care (Telemedicine / Telehealth Visits)</u> **Virtual Visits with Doctors who also provide services in person**		

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Primary Care (PCP)	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Mental Health and Substance Abuse care	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Specialist	$45 copay per visit deductible does not apply	30% coinsurance after deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups*	No charge	
Virtual Visits from Online Provider LiveHealth Online - *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	No charge for the first 3 visits and then $15 copay per visit deductible does not apply	
Specialist Care	$45 copay per visit deductible does not apply	
Visits in an Office		
Primary Care (PCP)	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Specialist Care	$45 copay per visit deductible does not apply	30% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal) *In-Network preventive prenatal services are covered at 100%.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Chiropractic Services *Coverage is limited to 26 visits per benefit period. Applies to In-Network. Limit is combined across professional visits and outpatient facilities. Does not include manipulation by a professional provider other than a chiropractor.*	50% coinsurance deductible does not apply	Not covered
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy	$45 copay per visit deductible does not apply‡	30% coinsurance after deductible is met
Dialysis/Hemodialysis	No charge	30% coinsurance after deductible is met
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Surgery	$45 copay per visit deductible does not apply‡	30% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services		
Lab		
Office *Office Cost Share applies only when Freestanding/Reference Labs are not used.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	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
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
Advanced Diagnostic Imaging - for example: MRI, PET and 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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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care *The Urgent Care cost share applies to both office and facility based Urgent Care providers. If your plan includes a copay for Urgent Care and additional services are provided, these services may be subject to deductible and coinsurance.*	$75 copay per visit deductible does not apply	30% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$300 copay per visit and 0% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance deductible does not apply	Covered as In-Network
Ambulance (Air and Ground)	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse		
Doctor Office Visit	$15 copay per visit deductible does not apply	30% coinsurance after deductible is met
Facility visit		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Doctor and Other Services		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<u>Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Abuse)</u>		
Facility fees (for example, room & board) *Coverage for Inpatient physical medicine and rehabilitation programs is limited to 60 days per benefit period. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 100 visits per benefit period. Private Duty Nursing included with Home Health Care is limited to 82 visits per calendar year, 164 visits per lifetime. Limit is combined In-Network and Non-Network. Benefit limit does not apply to Home Infusion Therapy. Benefit limit and cost share applies to Physical, Occupational, Speech, Respiratory, Cardiac and Pulmonary therapy when performed as part of Home Health.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy) *Coverage for Occupational Rehabilitation services is limited to 20 visits per benefit period. Coverage for Physical Rehabilitation services is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*		
Office	$45 copay per visit deductible does not apply	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy) *Coverage for Occupational Habilitation services is limited to 20 visits per benefit period. Coverage for Physical Habilitative services is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*		
Office	$45 copay per visit deductible does not apply	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.		
Office	$45 copay per visit deductible does not apply	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Pulmonary rehabilitation *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*		
Office	$45 copay per visit deductible does not apply	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 90 days per benefit period. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for Wigs is limited to one (1) item after cancer treatment per benefit period In-Network Providers and Non-Network Providers combined. Hearing Aids are not covered, unless newborn, no limit. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Essential drug list appear below. Drugs not included on the Essential drug list will not be covered. Your plan uses the Base Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		
Home Delivery Pharmacy *Maintenance medications are available through IngenioRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail) and $25 copay per prescription, deductible does not apply (home delivery)	Greater of $60 or 50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$35 copay per prescription, deductible does not apply (retail) and $105 copay per prescription, deductible does not apply (home delivery)	Greater of $60 or 50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$70 copay per prescription, deductible does not	Greater of $60 or 50% coinsurance, deductible does not

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	apply (retail) and $210 copay per prescription, deductible does not apply (home delivery)	apply (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	25% coinsurance up to $350 per prescription, deductible does not apply (retail and home delivery)	Greater of $60 or 50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

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Notes:

- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- 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.
- You are encouraged to select a Primary Care Physician (PCP). Choosing a PCP is an important decision. Call us at the number on your ID card and we'll help you pick a doctor.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- If services are rendered by a non-participating provider and your plan includes out of network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating provider's charge.
- Covered dependents are covered through the end of the month in which the child attains age 26.
- Limitations and Cost shares may vary by site of service. You should refer to your formal contract of coverage for details.
- Specialty Provider (SCP) is a professional provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.
- 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 your plan includes out of network benefits, all services with calendar year limits are combined both in and out of network.
- Extent of Coverage of Non-Emergency Care Outside the US is Full Access to the BlueCard network.
- Covered accidental dental services are covered up to $3000 per accident for professional services only.
- Elective Abortion - not covered.
- No Charge means you will not have to pay deductible, copayment and/or coinsurance cost shares up to the maximum allowable amount.
- 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.
- Primary Care Physician (PCP) is a professional provider who is a practitioner who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other professional provider as allowed by the plan.
- To view your prescription formulary list log on to www.anthem.com/health-insurance/customer-care/forms-library.
- Benefit period refers to calendar year.

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 (833) 953-1754

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 1754-953 (833) .

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) 953-1754:

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) 953-1754。

Farsi (فارسي) : 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) 953-1754 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) 953-1754.

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) 953-1754.

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih nínízingo kojį' hodíílnih (833) 953-1754.

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) 953-1754.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 953-1754 ਤੇ ਕਾਲ ਕਰੋ।

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Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (833) 953-1754.

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) 953-1754.

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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.