

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Convenient Care HMO 1000/20%/6500 Rx \$200D 15/45/75/30% Essential Tiered Rx

Your Network: HMO

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	\$55 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 <i>Your plan applies a separate Pharmacy Deductible to prescription drugs obtained at a pharmacy. See the Covered Prescription Drug Benefits section.</i>	\$1,000 member / \$3,000 family	Not covered
Overall Out-of-Pocket Limit	\$6,500 member / \$13,000 family	Not covered
<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>		
Doctor Visits (virtual and office) <i>Your plan requires the selection of a Primary Care Physician (PCP). A referral from your Primary Care Physician (PCP) is required for Specialist care and most other providers for select covered services.</i>		
Preferred PCP <i>virtual and office</i>	virtual -No charge office -No charge deductible does not apply	Not covered
Primary Care (PCP) <i>virtual and office</i>	\$45 copay per visit deductible does not apply	Not covered
Mental Health and Substance Use Disorder Services <i>virtual and office</i>	No charge deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Specialist Care <i>virtual and office</i>	\$55 copay per visit deductible does not apply	Not covered
<u>Other Practitioner Visits</u> Maternity Doctor services (prenatal/postnatal care and delivery) Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i> Spinal Manipulation <i>Coverage is limited to 20 visits per benefit period.</i> Acupuncture <i>Coverage is limited to 20 visits per benefit period.</i>	\$300 copay per pregnancy deductible does not apply \$45 copay per visit deductible does not apply \$45 copay per visit deductible does not apply \$45 copay per visit deductible does not apply	Not covered Not covered Not covered Not covered
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs <i>Dispensed in the office</i> Surgery	\$55 copay per visit deductible does not apply [†] 20% coinsurance after deductible is met \$55 copay per visit deductible does not apply [†]	Not covered Not covered Not covered
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Not covered
<u>Diagnostic Services</u> Lab Office Freestanding Lab/Reference Lab Outpatient Hospital	\$55 copay per visit deductible does not apply [†] 20% coinsurance after deductible is met 20% coinsurance after deductible is met	Not covered Not covered Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p>X-Ray</p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>\$55 copay per visit deductible does not apply[†]</p> <p>\$55 copay per visit deductible does not apply[†]</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p>Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>\$300 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care <i>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.</i></p> <p>Emergency Room Facility Services</p> <p>Emergency Room Doctor and Other Services <i>There may be other levels of cost share that are contingent on how services are provided.</i></p> <p>Ambulance</p>	<p>\$45 copay per visit deductible does not apply</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>Not covered</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p>Outpatient Mental Health and Substance Use Disorder Services at a Facility</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>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Physician and other services <i>including surgeon fees</i></p> <p>Hospital</p> <p>Ambulatory Surgical Center</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>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></p> <p>Facility Fees</p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</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>Not covered</p>
<p>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></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$45 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Pulmonary rehabilitation</p> <p>Office</p>	<p>\$55 copay per visit deductible does not apply</p>	<p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period.</i>		
Office	\$55 copay per visit deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	Not covered
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	20% coinsurance after deductible is met	Not covered
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	Not covered
Inpatient Hospice	20% coinsurance after deductible is met	Not covered
Durable Medical Equipment	20% coinsurance after deductible is met	Not covered
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	Not covered

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 <i>combined for Preferred Network and In-Network Pharmacies</i>	\$200 person / \$400 family (does not apply to Tier 1 drugs)	\$200 person / \$400 family (does not apply to Tier 1 drugs)	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Not covered

Prescription Drug Coverage
Network: Rx Choice Tiered Network
Drug List: Essential *Drugs not included on the Essential drug list will not be covered.*

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>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 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. 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. 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, Pharmacy deductible does not apply (retail) and \$37.50 copay per prescription, Pharmacy deductible does not apply (home delivery)	\$25 copay per prescription, Pharmacy deductible does not apply (retail only)	Not covered (retail and home delivery)
Tier 2 - Typically Preferred Brand	\$45 copay per prescription after Pharmacy deductible is met (retail) and \$112.50 copay per prescription after Pharmacy deductible is met (home delivery)	\$55 copay per prescription after Pharmacy deductible is met (retail only)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	\$75 copay per prescription after Pharmacy deductible is met (retail) and \$225 copay per prescription after Pharmacy deductible is met (home delivery)	\$85 copay per prescription after Pharmacy deductible is met (retail only)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	30% coinsurance up to \$500 per prescription after Pharmacy deductible is met (retail and home delivery)	30% coinsurance up to \$600 per prescription after Pharmacy deductible is met (retail only)	Not covered (retail and 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.
- ‡ You will pay the Preferred PCP or PCP's office visit copay when services are provided in their office.

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.

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

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Your Network: HMO

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

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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.

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Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'ídiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níl hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo koj' hodiilnih (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

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>.