Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Convenient Care HMO HSA 1650/10%/3000A Rx 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 after deductible is met
Mental Health & Substance Use Disorder Services	No charge after deductible is met
Specialist care	$75 copay per visit after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	$1,650 member / $3,300 family	Not covered
Overall Out-of-Pocket Limit	$3,000 member / $6,000 family	Not covered
The family deductible and out-of-pocket limit are non-embedded, meaning the cost shares of all family members apply to one family deductible and one family out-of-pocket limit. The per member deductible and per member out-of-pocket limit apply to individuals enrolled under single-only coverage. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.		
Doctor Visits (virtual and office) *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.*		
Preferred PCP *virtual and office*	No charge after deductible is met	Not covered
Primary Care (PCP) *virtual and office*	$45 copay per visit after deductible is met	Not covered
Mental Health and Substance Use Disorder Services *virtual and office*	No charge after deductible is met	Not covered
Specialist Care *virtual and office*	$75 copay per visit after deductible is met	Not covered
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	$300 copay per pregnancy after deductible is met	Not covered

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.*	$45 copay per visit after deductible is met	Not covered
Spinal Manipulation *Coverage is limited to 20 visits per benefit period.*	$45 copay per visit after deductible is met	Not covered
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$45 copay per visit after deductible is met	Not covered
Other Services in an Office		
Allergy Testing	$75 copay per visit after deductible is met‡	Not covered
Prescription Drugs *Dispensed in the office*	10% coinsurance after deductible is met	Not covered
Surgery	$75 copay per visit after deductible is met‡	Not covered
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Diagnostic Services		
Lab		
Office	$75 copay per visit after deductible is met‡	Not covered
Freestanding Lab/Reference Lab	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
X-Ray		
Office	$75 copay per visit after deductible is met‡	Not covered
Freestanding Radiology Center	$75 copay per visit after deductible is met‡	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered

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 per visit after deductible is met	Not covered
Freestanding Radiology Center	10% coinsurance after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$45 copay per visit after deductible is met	Not covered
Emergency Room Facility Services	10% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance after deductible is met	Covered as In-Network
Ambulance	10% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	10% coinsurance after deductible is met	Not covered
Doctor Services	10% coinsurance after deductible is met	Not covered
Outpatient Surgery		
Facility Fees		
Hospital	10% coinsurance after deductible is met	Not covered
Ambulatory Surgical Center	10% coinsurance after deductible is met	Not covered
Physician and other services *including surgeon fees*		
Hospital	10% coinsurance after deductible is met	Not covered
Ambulatory Surgical Center	10% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	10% coinsurance after deductible is met	Not covered
Physician and other services *including surgeon fees*	10% coinsurance after deductible is met	Not covered
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	10% coinsurance after deductible is met	Not covered
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	$45 copay per visit after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Pulmonary rehabilitation		
Office	$75 copay per visit after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$75 copay per visit after deductible is met	Not covered
Outpatient Hospital	10% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis *office and outpatient hospital*	10% coinsurance after deductible is met	Not covered
Chemo/Radiation Therapy *office and outpatient hospital*	10% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	10% coinsurance after deductible is met	Not covered
Inpatient Hospice	10% coinsurance after deductible is met	Not covered
Durable Medical Equipment	10% coinsurance after deductible is met	Not covered
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment up to a $500 maximum per member.*	10% 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	Combined with In-Network medical deductible	Combined with In-Network medical deductible	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.*			
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.*			
Tier 1 - Typically Generic	10% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail only)	Not covered (retail and home delivery)

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
Tier 2 - Typically Preferred Brand	10% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail only)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	10% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail only)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	10% coinsurance after deductible is met (retail and home delivery)	20% coinsurance after deductible is met (retail only)	Not covered (retail and home delivery)

Notes:

- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- 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.

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

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Your Plan: Anthem Convenient Care HMO HSA 1650/10%/3000A Rx Essential Tiered Rx
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.

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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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.

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Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo 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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