

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Preferred Plus POS HSA Option E1 with Rx Option T4

Your Network: Blue Preferred

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$2,800 person / \$5,600 family	\$5,600 person / \$11,200 family
<b>Out-of-Pocket Limit</b>	\$3,500 person / \$7,000 family	\$7,000 person / \$14,000 family
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum.</p> <p>All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	30% coinsurance after deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	30% coinsurance after deductible is met
<b><u>Virtual Care (Telemedicine / Telehealth Visits)</u></b>		
<b>Virtual Visits - Online visits with Doctors who also provide services in person</b>		
Primary Care (PCP)	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Mental Health and Substance Abuse care	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Specialist	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Medical Chats and Virtual (Video) Visits for Primary Care</b> from our Online Provider K Health, through its affiliated Provider groups	0% coinsurance after deductible is met	

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Virtual Visits from Online Provider LiveHealth Online</b> via <a href="http://www.livehealthonline.com">www.livehealthonline.com</a>; our mobile app, website or Anthem-enabled device</p> <p>Primary Care (PCP) and Mental Health and Substance Abuse</p> <p>Specialist Care</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	
<p><b><u>Visits in an Office</u></b></p> <p><b>Primary Care (PCP)</b></p> <p><b>Specialist Care</b></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><b><u>Other Practitioner Visits</u></b></p> <p><b>Routine Maternity Care</b> (Prenatal and Postnatal)</p> <p><b>Retail Health Clinic</b></p> <p><b>Manipulation Therapy</b></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>
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b></p> <p><b>Chemo/Radiation Therapy</b></p> <p><b>Dialysis/Hemodialysis</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i></p> <p><b>Surgery</b></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>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> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></p> <p>Office</p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>X-Ray</b> Office Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u><b>Emergency and Urgent Care</b></u> <b>Urgent Care</b> <b>Emergency Room Facility Services</b> <b>Emergency Room Doctor and Other Services</b> <b>Ambulance</b>	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u><b>Outpatient Mental Health and Substance Abuse</b></u> <b>Doctor Office Visit</b> <b>Facility Visit</b> Facility Fees Doctor Services	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p><b>Doctor and Other Services</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</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>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> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></b></p> <p><b>Facility Fees</b></p> <p><b>Human Organ and Tissue Transplants</b> <i>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i></p> <p><b>Doctor and other services</b></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>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Rehabilitation services</b> <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 40 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</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>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Cardiac rehabilitation</b> <i>Coverage is limited to 36 visits per benefit period.</i> Office Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<b>Pulmonary rehabilitation</b> <i>Coverage is limited to 20 visits per benefit period.</i> Office Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<b>Skilled Nursing Care (facility)</b> <i>Coverage is limited to 30 days per admission.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Inpatient Hospice</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Pharmacy Deductible</b>	Combined with In-Network medical deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
<b>Prescription Drug Coverage</b> <i>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 Rx Choice Tiered Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.</i>			

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p><b>Home Delivery Pharmacy</b> Maintenance medication are available through IngenioRx 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.</p>			
<p><b>Preventive Drugs</b> Your Pharmacy cost share is reduced for drugs included on the PreventiveRX Plus drug list, a designated list of drugs for the treatment of diabetes, asthma, depression, heart health, high blood pressure, high cholesterol, and osteoporosis.</p>			
<p><b>Tier 1 Preventive - Typically Generic</b> Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p> <p><b>Tier 2 Preventive - Typically Preferred Brand</b> Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p>	<p>\$10 copay per prescription, deductible does not apply (retail) and \$25 copay per prescription, deductible does not apply (home delivery)</p> <p>\$50 copay per prescription, deductible does not apply (retail) and \$150 copay per prescription, deductible does not apply (home delivery)</p>		<p>50% coinsurance after deductible is met (retail) and Not covered (home delivery)</p> <p>50% coinsurance after deductible is met (retail) and Not covered (home delivery)</p>
<p><b>Tier 1 - Typically Generic</b> Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p>	<p>\$10 copay per prescription after deductible is met (retail) and \$25 copay per prescription after deductible is met (home delivery)</p>	<p>\$20 copay per prescription after deductible is met (retail) and Not covered (home delivery)</p>	<p>50% coinsurance after deductible is met (retail) and Not covered (home delivery)</p>
<p><b>Tier 2 – Typically Preferred Brand</b> Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p>	<p>\$50 copay per prescription after deductible is met (retail) and \$150 copay per prescription after deductible is met (home delivery)</p>	<p>\$60 copay per prescription after deductible is met (retail) and Not covered (home delivery)</p>	<p>50% coinsurance after deductible is met (retail) and Not covered (home delivery)</p>
<p><b>Tier 3 - Typically Non-Preferred Brand</b> Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p>	<p>\$80 copay per prescription after deductible is met (retail) and \$240 copay per prescription after deductible is met (home delivery)</p>	<p>\$90 copay per prescription after deductible is met (retail) and Not covered (home delivery)</p>	<p>50% coinsurance after deductible is met (retail) and Not covered (home delivery)</p>
<p><b>Tier 4 - Typically Specialty (brand and generic)</b> Per 30 day supply (specialty pharmacy).</p>	<p>25% coinsurance up to \$350 per prescription after deductible is met</p>	<p>25% coinsurance up to \$450 per prescription after deductible is met</p>	<p>50% coinsurance after deductible is met</p>

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	(retail and home delivery)	(retail) and Not covered (home delivery)	(retail) and Not covered (home delivery)
Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider	
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i>			
<b><u>Children's Vision (up to age 19)</u></b>			
<b>Child Vision Deductible</b>		\$0 person	\$0 person
<b>Vision exam</b> <i>Limited to 1 exam per benefit period.</i>		No charge	\$0 copayment up to plan's Maximum Allowed Amount
<b><u>Adult Vision (age 19 and older)</u></b>			
<b>Adult Vision Deductible</b>		\$0 person	\$0 person
<b>Vision exam</b> <i>Limited to 1 exam per benefit period.</i>		No charge	Reimbursed Up to \$42

**Notes:**

- Dependent age: to end of the month in which the child attains age 26.
- 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.
- 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.
- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care 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.

*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.*

## Your Plan: Anthem Blue Preferred Plus POS HSA Option E1 with Rx Option T4

### Your Network: Blue Preferred

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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Questions: (833) 578-4439 or visit us at [www.anthem.com](http://www.anthem.com)

WI/LG/Anthem Blue Preferred Plus POS HSA Option E1 with Rx Option T4/6D0G/01-01-2022



## 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) 578-4439

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) 578-4439.

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## Language Access Services:

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**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) 578-4439.

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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>.