Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Anthem Blue Access PPO Option A

Your Network: Blue Access

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 *See notes section to understand how your deductible works.*	$750 person / $1,500 family	$1,500 person / $3,000 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.*	$2,500 person / $5,000 family	$6,000 person / $12,000 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness *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.*	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office*	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met

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visit, there is no additional cost to the member for the injection. **LiveHealth Online**	**$10 copay**	
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	20% coinsurance after deductible is met-***Inpatient Hospital***	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
On-line Visit	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy-Chiropractic *Coverage is limited to 26 visits per benefit period. Visit limits are combined both across outpatient and other professional visits.*	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	$10 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Primary Care Physician	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Specialist	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Dialysis/Hemodialysis	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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Diagnostic Services		
Lab:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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Emergency and Urgent Care		
Urgent Care (Office Setting) *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.*	$50 copay per visit deductible does not apply	Covered as In-Network
Urgent care(Facility Setting)		
Urgent Care: Facility fees	$50 copay per visit deductible does not apply	Covered as In-Network
Urgent Care: Doctor and other services	$50 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Facility Services *Copay waived if admitted.*	$200 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	$200 copay per visit	Covered as In-Network
Ambulance (Air, Ground, and Water)	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs is limited to 60 days combined per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants *Acquisition and transplant procedures, harvest and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	No charge	30% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for Occupational Therapy and Physical Therapy is limited to 44 visits per benefit period combined, and Speech Therapy is limited to 20 visits per benefit period. Coverage for Occupational Rehabilitation services, Physical Rehabilitation and Manipulation Therapy services is limited to 44 visits per benefit period. Limit excludes manipulation therapy by a Chiropractor. Limit is combined In-Network and Non-Network across professional and outpatient visits. Visit limits are combined both across outpatient and other professional visits.*	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Occupational Therapy and Physical Therapy is limited to 44 visits per benefit period combined, and Speech Therapy is limited to 20 visits per benefit period. Coverage for Occupational Rehabilitation services, Physical Rehabilitation and Manipulation Therapy services is limited to 44 visits per benefit period. Limit excludes manipulation therapy by a Chiropractor. Limit is combined In-Network and Non-Network across professional and outpatient visits. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both*	20% coinsurance after deductible is met	50% 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
across outpatient and other professional visits.		
Pulmonary rehabilitation Office *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 100 days per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs needed after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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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	Not Applicable	Not applicable
Pharmacy Out of Pocket	$2,000 person/ $3,000 Family	Combined with medical out of pocket maximum
Prescription Drug Coverage *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *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.*	$15 copay per prescription, deductible does not apply (retail) and $30 copay per prescription, deductible does not apply (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *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.*	$30 copay per prescription, deductible does not apply (retail) and $60 copay per prescription, deductible does not apply (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *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.*	$60 copay per prescription, deductible does not apply (retail) and $120 copay per prescription, deductible does not	50% coinsurance (retail) and Not covered (home delivery)

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	apply (home delivery)	
Tier 4 - Typically Specialty (brand and generic)-Preferred *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.*	20% coinsurance up to $200 per prescription , deductible does not apply (retail and home delivery)	Not Covered
Tier 5-Typically Specialty (brand and generic)-Non Preferred Covers up to a 30 day supply (retial pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary durgs.	20% coinsurance up to $250 per prescription , deductible does not apply (retail and home delivery)	Not Covered

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Notes:

- 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 year 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 (HOTT) Services).
- If office visit is a coinsurance, the coinsurance also applies to allergy injections.
- No Copayment or Coinsurance applies to certain diabetic and asthmatic supplies 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 - 20% coinsurance for Network/50% Non-Network Durable Medical Equipment, Medical Supplies, Orthotics, Asthma Supplies, and Phenylketonuria (PKU). Excludes Prosthetics, 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.
- 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 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).
- 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.

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- 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 in an office setting from a Physical therapist or Occupational Therapist, you will not have to pay an office visit Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.
- All covered expenses accumulate separately toward the preferred or non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.
- All covered expenses accumulate separately toward the preferred or non-preferred Out-of-Pocket Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Out-of-Pocket Limit. Pharmacy expenses do not apply towards the Out-of-Pocket Limit. The family Out-of-Pocket Limit is a cumulative Out-of-Pocket Limit for all family members. The family Out-of-Pocket Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Limit amount.