Your summary of benefits

Anthem® BlueCross and BlueShield

Your Contract Code: 4F2F

Your Plan: Anthem Platinum Blue Access PPO 0/10%/2800

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 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.*	$0 person / $0 family	$2,000 person / $4,000 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.*	$2,800 person / $5,600 family	$8,400 person / $16,800 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	$15 copay per visit	50% coinsurance after deductible is met
Specialist Care Visit	$35 copay per visit	50% 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
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	$500 copay per pregnancy	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$15 copay per visit	50% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse* *Live Health Online is the preferred telehealth solution.* *(www.livehealthonline.com).*	$10 copay per visit	50% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$15 copay per visit	50% coinsurance after deductible is met
Chiropractic *Coverage is limited to 12 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	$35 copay per visit	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office:		
Allergy Testing	$15 copay per visit	50% coinsurance after deductible is met
Chemo/Radiation Therapy	10% coinsurance	50% coinsurance after deductible is met
Hemodialysis	10% coinsurance	50% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	10% coinsurance	50% 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
Diagnostic Services		
Lab:		
Office *Office Cost Share applies only when Freestanding/Reference Labs are not used.*	10% coinsurance	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	$500 copay per visit	50% coinsurance after deductible is met
X-Ray:		
Office	10% coinsurance	50% coinsurance after deductible is met
Freestanding Radiology Center	$500 copay per visit	50% coinsurance after deductible is met
Outpatient Hospital	$500 copay per visit	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	$100 copay per service	50% coinsurance after deductible is met
Freestanding Radiology Center	$250 copay per service	50% coinsurance after deductible is met
Outpatient Hospital	$250 copay per service	50% 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
Emergency and Urgent Care		
Urgent Care (Office Setting)	$100 copay per visit	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$300 copay per visit	Covered as In-Network
Emergency Room Doctor and Other Services	10% coinsurance	Covered as In-Network
Emergency Room Mental/Behavioral Health and Substance Abuse Doctor Services	$15 copay per visit	Covered as In-Network
Ambulance (Air and Ground) *Non-emergency, Non-Network ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	10% coinsurance	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$15 copay per visit	50% coinsurance after deductible is met
Facility visit:		
Facility Fees	$500 copay per visit	50% coinsurance after deductible is met
Doctor Services	$35 copay per visit	50% 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
Outpatient Surgery		
Facility Fees:		
Hospital	$500 copay per visit	50% coinsurance after deductible is met
Freestanding Surgical Center	$500 copay per visit	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	10% coinsurance	50% coinsurance after deductible is met
Freestanding Surgical Center	10% coinsurance	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.*	$400 copay per day to a maximum of $1,600 per admission	50% coinsurance after deductible is met
Doctor and other services	10% coinsurance	50% 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. Visit limit does not apply to Home Infusion Therapy or Home Dialysis. Benefit limit applies to Physical, Occupational and Speech Therapy when performed as part of Home Health.*	10% coinsurance	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy): Office *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	$35 copay per visit	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	10% coinsurance	50% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy): Office *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	$35 copay per visit	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	10% coinsurance	50% 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
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	$35 copay per visit	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 across all outpatient settings.*	10% coinsurance	50% 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.*	$400 copay per day to a maximum of $1,600 per admission	50% coinsurance after deductible is met
Hospice	10% coinsurance	50% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network.*	10% coinsurance	50% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with In-Network medical out of pocket maximum	Combined with In-Network medical out of pocket maximum	Combined with Non-Network medical out of pocket maximum
Prescription Drug Coverage *Select 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.*	$10 copay per prescription (retail) and $25 copay per prescription (home delivery)	$20 copay per prescription (retail) and Not covered (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.*	$35 copay per prescription (retail) and $105 copay per prescription (home delivery)	$45 copay per prescription (retail) and Not covered (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.*	$70 copay per prescription (retail) and $210 copay per prescription (home delivery)	$80 copay per prescription (retail) and Not covered (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *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.*	25% coinsurance up to $300 per prescription (retail and home delivery)	25% coinsurance up to $400 per prescription (retail) and Not covered (home delivery)	50% coinsurance (retail) and Not covered (home delivery)

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Only children's vision services count towards your out of pocket limit.*		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	Not Applicable	Not Applicable
Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	No charge	Reimbursed Up to $30
Frames *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $45
Single Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $25
Bifocal Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $40
Trifocal Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $55
Elective contact lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $60
Non-Elective Contact Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	Reimbursed Up to $210
Adult Vision (age 19 and older)		
Adult Vision Deductible	Not Applicable	Not Applicable

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	$20 copay	Reimbursed Up to $30
Frames	Not covered	Not covered
Single Vision Lenses	Not covered	Not covered
Bifocal Vision Lenses	Not covered	Not covered
Trifocal Vision Lenses	Not covered	Not covered
Elective contact lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. *Only children's dental services count towards your out of pocket limit.*		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Coverage for In-Network Providers and Non-Network Providers is limited to 2 visits per 12 months.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Basic services	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Major services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Combined with medical deductible
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Annual maximum	Not covered	Not covered

Your summary of benefits

Notes:

- 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.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- 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 providers charge.
- All medical and pharmacy deductibles, copayments and coinsurance apply to the out of pocket maximum (excluding preventive services that meet the requirements of federal and state law received in network and Human Organ and Tissue Transplant (HOTT) services received out of network).
- 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.
- Primary Care Physician (PCP) is a professional provider who is a practitioner and specializes in either family practice, general practice, internal medicine, pediatrics or geriatrics or is any other professional provider as allowed by the plan.
- Certain diabetic and asthmatic supplies are covered subject to applicable prescription drug copayments/coinsurance when received from an in network pharmacy. These supplies are covered as medical supplies and durable medical equipment if received from an out of network pharmacy. Diabetic test strips are covered subject to applicable prescription drug copayment/coinsurance.
- Maternity hospital stays will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- Covered accidental dental services are covered up to $3000 per member per accident.
- Human Organ and Tissues Transplants require precertification.
- 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.
- For HSA compatible CDHP plans, any applicable Medical or Pharmacy copayments apply after the deductible has been met and accumulate to the Plan out of pocket maximum.
- All medical services subject to a coinsurance are also subject to the annual medical deductible with exception of facility emergency room charge.
- Covered in Full (CIF) means you will not have to pay deductible, copayment and/or coinsurance cost shares up to the maximum allowable amount.
- Elective abortions not covered unless otherwise noted in your Certificate of Coverage.

Your summary of benefits

- A Specialist copayment is applicable to care provided by Specialists, excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or other Network Provider as allowed by Plan.
- If readmitted within 72 hours for the same diagnosis of the previous discharge, no additional facility copayment is required. If transferred between facilities, only one copayment will apply.
- Vision services are not subject to the annual deductible.
- Benefit period refers to calendar year.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Diagnostic mammograms are not subject to Copayments / Coinsurance in Network office and outpatient facility settings.

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 (855) 330-1094

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 (855) 330-1094 .

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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 (855) 330-1094 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 (855) 330-1094.

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'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 ninízingo kojį' hodíilnih (855) 330-1094.

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: (855) 330-1094.

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, (855) 330-1094 ਤੇ ਕਾਲ ਕਰੋ।

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