Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Essential Open Access POS OAP12 5000/30%/7900 L

Your Network: Blue Open Access POS

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$5,000 member / $10,000 family	$15,000 member / $30,000 family
Out-of-Pocket Limit	$7,900 member / $15,800 family	$23,700 member / $47,400 family
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.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Visit	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prenatal and Post-natal Care	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental Health and Substance Abuse*	No charge for the first 12 visits and then $30 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other Participating Provider On-line Visit *Includes Mental Health and Substance Abuse*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy	Not covered	Not covered
Acupuncture	Not covered	Not covered
Other Services in an Office:		
Allergy Testing	Not covered	Not covered
Chemo/Radiation Therapy	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services **Lab:**		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging:		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care	$75 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Cost share waived if admitted.*	$350 copay per visit and 30% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	30% coinsurance deductible does not apply	Covered as In-Network
Ambulance	30% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility Visit:		
Facility Fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees:		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	$150 copay per visit deductible does not apply	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	$500 copay per admission and 30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Doctor and other services	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services:		
Office	Not covered	Not covered
Outpatient Hospital	Not covered	Not covered
Cardiac rehabilitation		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per benefit period.*	$500 copay per admission and 30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Hospice	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	$500 person / $1,000 family	$500 person / $1,000 family
Pharmacy Out of Pocket	Combined with medical	Combined with medical
Prescription Drug Coverage *Standard with R90* *Essential Drug List* *Up to a 90 day supply is available at most retail pharmacies. No coverage for non-formulary drugs.*		
Tier 1 - Typically Generic *90 day supply (retail pharmacy). 90 day supply (home delivery).*	$15 copay per prescription, Pharmacy deductible does not apply (retail and home delivery)	$15 copay per prescription, Pharmacy deductible does not apply (retail only)
Tier 2 – Typically Preferred Brand *90 day supply (retail pharmacy). 90 day supply (home delivery).*	$40 copay per prescription after Pharmacy deductible is met (retail) and $80	$40 copay per prescription after Pharmacy deductible is met (retail only)

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	copay per prescription after Pharmacy deductible is met (home delivery)	
Tier 3 - Typically Non-Preferred Brand *90 day supply (retail pharmacy). 90 day supply (home delivery).*	$75 copay per prescription after Pharmacy deductible is met (retail) and $225 copay per prescription after Pharmacy deductible is met (home delivery)	$75 copay per prescription after Pharmacy deductible is met (retail only)
Tier 4 - Typically Specialty (brand and generic) *30 day supply (retail pharmacy). 30 day supply (home delivery).*	25% coinsurance up to $350 per prescription after Pharmacy deductible is met (retail and home delivery)	25% coinsurance up to $350 per prescription after Pharmacy deductible is met (retail only)

Notes:

- Your copays, coinsurance and deductible count toward your out of pocket amount.
- If you have a 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" which is generally coinsurance or coinsurance after your deductible is met.
  Costs may also 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 Certificate of Coverage. If there is a difference between this summary and the Certificate of Coverage the Certificate of Coverage will prevail.

Your Plan: Anthem Blue Essential Open Access POS OAP12 5000/30%/7900 L
Your Network: Blue Open Access POS

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:

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(TTY/TDD: 711)

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Language Access Services:

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