Your summary of benefits

Anthem BlueCross and BlueShield

Your Contract Code: 3J6L

Your Plan: Anthem Silver Blue Open Access POS 6000/20%/7900 Focus

Your Network: Blue Open Access POS

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.*	$6,000 person / $12,000 family	$18,000 person / $54,000 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.*	$7,900 person / $15,800 family	$23,700 person / $71,100 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Non-Network preventive care services for children prior to their 6th birthday have no deductible.*	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Office Visit to treat an injury or illness	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Office Visit	$80 copay per visit deductible does not apply	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	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$40 copay per visit deductible does not apply	50% coinsurance after deductible is met
On-line Visit *Live Health Online is the preferred telehealth solutions (www.livehealthonline.com)*	No charge for the first 12 visits and then $40 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network across all outpatient settings.*	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hemodialysis	20% coinsurance after deductible is met	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

Your summary of benefits

Diagnostic Services		
Lab:		
Office *Office Cost Share applies only when Freestanding/Reference Labs are not used.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	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
X-Ray:		
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
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
Emergency and Urgent Care		
Urgent Care (Office Setting)	$100 copay per visit deductible does not apply	50% coinsurance after deductible is met

Your summary of benefits

Emergency Room Facility Services *Copay waived if admitted.*	$300 copay per visit after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance (Air and Ground)	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit and Online Visit	$40 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
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

Your summary of benefits

Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder):		
Facility fees (for example, room & board) *Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-Network Providers combined is limited to 60 days per benefit year.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Care Visits *Coverage for In-Network Providers and Non-Network Providers combined is limited to 120 visits per benefit period. Visit limit does not apply to Physical, Occupational or Speech Therapy when performed as part of Home Health.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Non-Network Providers combined. Visit limits are combined both across outpatient and other professional visits*	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Non-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Non-Network Providers combined. Visit limits are combined both across outpatient and other professional visits.*	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met

Outpatient Hospital *Coverage for physical therapy and occupational therapy combined is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers and Non-Network Providers combined. 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	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage for Inpatient rehabilitation and skilled nursing services combined In-Network Providers and Non-Network Providers combined is limited to 60 days per benefit period.*	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 *Coverage for hearing aids services left ear is limited to 1 unit every 48 months and right ear is limited to 1 unit every 48 months for children 18 years of age or under. Coverage is limited to $3,000 per hearing aid. Apply to In-Network Providers and Non-Network Providers combined.*	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs needed after cancer treatment In-Network Providers and Non-Network Providers combined is limited to 1 items per benefit period.*	50% coinsurance after deductible is met	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	Combined with medical deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum	Combined with 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 1a - Typically Lower Cost 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.*	$5 copay per prescription, deductible does not apply (retail only). $13 copay per prescription, deductible does not apply (home delivery only).	$15 copay per prescription, deductible does not apply (retail only).	50% coinsurance deductible does not apply (retail only).
Tier 1b - 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.*	$20 copay per prescription, deductible does not apply (retail only). $50 copay per prescription, deductible does not apply (home delivery only).	$30 copay per prescription, deductible does not apply (retail only).	50% coinsurance deductible does not apply (retail only).
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.*	$50 copay per prescription, deductible does not apply (retail only). $150 copay per prescription, deductible does not	$60 copay per prescription, deductible does not apply (retail only).	50% coinsurance deductible does not apply (retail only).

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
	apply (home delivery only).		
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.*	$90 copay per prescription after deductible is met (retail only). $270 copay per prescription after deductible is met (home delivery only).	$100 copay per prescription after deductible is met (retail only).	50% coinsurance after deductible is met (retail only).
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.*	20% coinsurance after deductible is met (retail and home delivery).	20% coinsurance after deductible is met (retail only).	50% coinsurance after deductible is met (retail only).

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.		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	$0 person	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
Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$25 Reimbursement for Single, $40 Reimbursement for Bifocal and $55 Reimbursement for Trifocal Vision Lens
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	$0 person	Not Applicable
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

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Frames	Not covered	Not covered
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 combined is limited to 2 visits per benefit period.*	10% coinsurance deductible does not apply	10% coinsurance deductible does not apply
Basic services	40% coinsurance after deductible is met	40% coinsurance after deductible is met
Major services	40% coinsurance after deductible is met	40% coinsurance after deductible is met
Medically Necessary Orthodontia services	40% coinsurance after deductible is met	40% 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 Applicable	Not Applicable

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Annual maximum	Not covered	Not covered

Your summary of benefits

Notes:

- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefit Coverage."
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- 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.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.
- The family deductible and out-of-pocket maximum are embedded indicating the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; additionally, 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.
- All medical and pharmacy deductibles, copayments and coinsurance apply to the out of pocket maximum.
- Physical Therapy: Athletic Trainers are covered by mandate for out-of-network only since athletic trainers are not contracted nor credentialed, therefore are not “in-network”.
- Covered out-of-network Human Organ and Tissue Transplant services do not apply toward the out-of-pocket limit.
- Home Delivery Choice for Maintenance Drugs - You may get the first 30 day supply and up to one more 30 day refill of the same Maintenance Medication at a retail pharmacy. Prior to the 3rd refill, you must contact us at 888-772-5188 or at www.anthem.com and tell us if you would like to keep getting your Maintenance Medications from the retail pharmacy or if you would like 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.
- Level 1 Pharmacies include, but are not limited to, CVS, Target, Walmart, Kroger, Safeway, Costco, Ingles and Fred's. Level 2 Pharmacies include, but are not limited to, Publix, Rite Aid and Walgreens. For a complete list of Level 1 and Level 2 pharmacies, you can go to www.anthem.com/pharmacyinformation and select Rx Networks and then Rx Choice Tiered Network pharmacies.

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 (855) 837-8541

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(TTY/TDD: 711)

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