Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Contract Code: 5T55

Your Plan: CSP Blue Open Access POS 1500/0%/3000

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.*	$1,500 person / $3,000 family	$4,500 person / $13,500 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 the year. See notes section for additional information regarding your out of pocket maximum.*	$3,000 person / $6,000 family	$9,000 person / $27,000 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 Visit to treat an injury or illness	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Office Visit and Online Visit	$70 copay per visit deductible does not apply	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
Prenatal and Post-natal Care	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$30 copay per visit deductible does not apply	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).*	No charge for the first 12 visits and then $30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental/Behavioral 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 by a Primary Care Physician - Office	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Allergy Testing by a Specialist Physician - Office	$70 copay per visit deductible does not apply	50% coinsurance after deductible is met
Radiation/Chemotherapy/Non Preventive Infusion & Injection	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Hemodialysis	0% coinsurance after deductible is met	50% coinsurance after deductible is met

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Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Lab by a Primary Care Physician - Office	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Lab by a Specialist Physician - Office	$70 copay per visit deductible does not apply	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
X-Ray by a Primary Care Physician - Office	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
X-Ray by a Specialist Physician - Office	$70 copay per visit deductible does not apply	50% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		

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Office	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	$350 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care (Office Setting)	$75 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$350 copay per visit after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Mental/Behavioral Health and Substance Abuse Doctor Services	$30 copay per visit after deductible is met	Covered as In-Network
Ambulance (Air and Ground)	0% 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	0% coinsurance after deductible is met	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
Doctor Services	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	$350 copay per visit deductible does not apply	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance deductible does not apply	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 Rehabilitation and Skilled Nursing services is limited to 60 days combined per year. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	0% 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
Recovery & Rehabilitation **Home Health Care** *Coverage is limited to 120 visits per year. Limit is combined In-Network and Non-Network. Limit does not apply to separate Physical or Occupational or Speech Therapy limits, when performed as part of Home Health.*	0% 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 is limited to 20 visits combined per year. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for Speech Therapy is limited to 20 visits per year. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for Physical Therapy and Occupational Therapy is limited to 20 visits combined per year. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities. Coverage for Speech Therapy is limited to 20 visits per year. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation Office	$70 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	0% 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 is limited to 60 days combined per year. Limit is combined In-Network and Non-Network.*	0% 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
Hospice	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	0% 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 *Deductible does not apply (retail and home delivery).*	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Standard with R90* *Essential 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) and $13 copay per prescription, deductible does not apply (home delivery)	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) and $50 copay per prescription, deductible does not apply (home delivery)	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) and $150 copay per prescription,	50% coinsurance, deductible does not apply (retail only)

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	deductible does not apply (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.*	$85 copay per prescription, deductible does not apply (retail) and $255 copay per prescription, deductible does not apply (home delivery)	50% coinsurance, deductible does not apply (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, deductible does not apply (retail and home delivery)	50% coinsurance, deductible does not apply (retail only)

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Your plan also includes the following Healthy Support & Rewards features. *To see your rewards and additional information log into the Anthem website at anthem.com or call the customer service number on your member ID card.*		
My Health Rewards	Subscriber and spouse/domestic partner may earn rewards for participating in this program. If you participate, you will earn points by completing designated activities and milestones. The points will be redeemed for rewards. At each of the three milestones, the member can earn $50.	Up to $150 per member per year.
Processed Claim: Adult Wellness Exam	Subscriber and spouse/domestic partner may earn a reward if you complete an annual preventive wellness exam and it is verified by an Anthem claim. This activity requires completion of the Annual Flu Shot in order to earn the rewards.	Up to $25 per member per year.
Processed Claim: Annual Flu Shot	Subscriber and spouse/domestic partner may earn a reward if you get your annual flu shot and it is verified by an Anthem claim. This activity requires completion of the Adult Wellness Exam in order to earn the rewards.	Up to $25 per member per year.

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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 provider's charge.
- 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".
- 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.
- Opt-out Home Delivery for Maintenance Drugs (previously known as Home Delivery Choice) – For medications on your benefit plan's maintenance drug list, you may get your first 30-day supply and up to one more 30-day refill of the same Maintenance Medication at an in-network retail pharmacy. Prior to your 3rd fill, you must contact us at 1-833-203-1739 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 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.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Covered out-of-network Human Organ and Tissue Transplant services do not apply toward the out-of-pocket limit.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

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 (844) 230-3683

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 (844) 230-3683 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (844) 230-3683:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(844) 230-3683。

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 (844) 230-3683 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 (844) 230-3683.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (844) 230-3683.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 230-3683.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(844) 230-3683 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(844) 230-3683로 문의하십시오.

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 (844) 230-3683.

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: (844) 230-3683.

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, (844) 230-3683 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (844) 230-3683.

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Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (844) 230-3683.

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.