Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your 2022 Contract Code: 5BG2

Your Plan: CSP Blue Open Access POS 1500/0%/3500

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.*	$3,500 person / $7,000 family	$10,500 person / $31,500 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
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits) **Virtual Visits with Doctors who also provide services in person**		
Primary Care (PCP)	$30 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
Mental Health and Substance Abuse care	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist	$70 copay per visit deductible does not apply	50% coinsurance after deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups*	No charge	
Virtual Visits from Online Provider LiveHealth Online - *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*		
Primary Care (PCP) and Mental Health and Substance Abuse	No charge for the first 12 visits and then $30 copay per visit deductible does not apply	
Specialist Care	$70 copay per visit deductible does not apply	
Visits in an Office		
Primary Care (PCP)	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care	$70 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy	Not covered	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	$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
Dialysis/Hemodialysis	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection.*	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	$70 copay per visit deductible does not apply‡	50% coinsurance after deductible is met
Diagnostic Services		
Lab		
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

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray		
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 and CAT scans		
Office	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	$300 copay per service 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

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency Room Mental 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 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
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

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital Stay (all Inpatient stays including Maternity, Mental 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
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 120 visits per year. Limit is combined In-Network and Non-Network. Benefit limit and cost share applies to Physical, Occupational, Speech, Respiratory, Cardiac and Pulmonary therapy 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) *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.*		
Office	$30 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
Habilitation services (for example, physical/speech/occupational therapy) *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.*		

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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.		
Office	$30 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
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
Pulmonary 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
Inpatient Hospice	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
Durable Medical Equipment	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per year. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible *Deductible does not apply (retail and home delivery).*	Not applicable	Not applicable
Pharmacy Out of Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Essential drug list appear below. Drugs not included on the Essential drug list will not be covered. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		
Home Delivery Pharmacy *Maintenance medications are available through IngenioRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		
Tier 1a - Typically Lower Cost Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$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 *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$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 *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$50 copay per prescription, deductible does not	50% coinsurance, deductible does not apply (retail only)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	apply (retail) and $150 copay per prescription, deductible does not apply (home delivery)	
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$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) *Per 30 day supply (specialty pharmacy).*	20% coinsurance, deductible does not apply (retail and home delivery)	50% coinsurance, deductible does not apply (retail only)

Your summary of benefits

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.*		
Smart Rewards	Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.	Up to $200 per member per year

Your summary of benefits

Notes:

- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- 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.
- You are encouraged to select a Primary Care Physician (PCP). Choosing a PCP is an important decision. Call us at the number on your ID card and we'll help you pick a doctor.
- 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 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 230-3683 (844) .

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 230-3683 (844) 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.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (844) 230-3683.

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (844) 230-3683.

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.