

# Your summary of benefits



Anthem® Blue Cross and Blue Shield  
 Your Plan: Anthem Blue Access PPO  
 Professional International and Domestic  
 Your Network: Blue Access

Effective: 08/01/2024

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
<b>Primary Care, and medical services for urgent/acute care</b>	\$25 copay per visit medical deductible does not apply
<b>Mental Health &amp; Substance Use Disorder Services</b>	\$25 copay per visit medical deductible does not apply
<b>Specialist care</b>	\$35 copay per visit medical deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$350 person / \$1050 family	\$700 person / \$2,100 family
<b>Overall Out-of-Pocket Limit</b>	\$5,000 person / \$10,000 family	\$5,000 person / \$10,000 family

The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.

In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.

**Doctor Visits (virtual and office)** *You are encouraged to select a Primary Care Physician (PCP).*

<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	\$25 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	\$35 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
<b>University Health Services (UHS)</b>	\$15 Copayment per visit No Deductible	Not Covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Other Practitioner Visits</u></b></p> <p><b>Routine Maternity Care</b> (Prenatal and Postnatal)</p> <p><b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p> <p><b>Manipulation Therapy</b> <i>Coverage is limited to 12 visits per benefit period.</i></p>	<p>\$25 copay per visit medical deductible does not apply</p> <p>\$25 copay per visit medical deductible does not apply</p> <p>\$35 copay per visit medical deductible does not apply</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i></p> <p><b>Surgery</b></p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>\$25/\$35 copay per visit medical deductible does not apply<sup>‡</sup></p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><b>Preventive care / screenings / immunizations</b></p>	<p>No charge</p>	<p>50% coinsurance after medical deductible is met</p>
<p><b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>50% coinsurance after medical deductible is met</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></p> <p>Office</p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p>	<p>No charge if billed with office visit copay</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>X-Ray</b></p> <p>Office -- No charge if billed with copay.</p> <p>Outpatient Hospital</p>	<p>No Charge</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p><b>Emergency Room Facility Services</b> <i>Your copay will be waived if admitted.</i></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b></p>	<p>\$50 copay per visit medical deductible does not apply</p> <p>\$150 copay per visit medical deductible does not apply</p> <p>No charge</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p><b>Physician and other services <i>including surgeon fees</i></b></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b></p> <p><b>Facility Fees</b></p> <p><b>Human Organ and Tissue Transplants</b> <i>Cornea transplants are treated the same as any other illness and subject to the medical benefits.</i></p> <p><b>Physician and other services <i>including surgeon fees</i></b></p>	<p>\$200 copay per admission</p> <p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period.</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p>
<p><b>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i></b> <i>Coverage for rehabilitative and habilitative Physical Therapy is limited to 60 visits combined per benefit period. Coverage for rehabilitative and habilitative Occupational Therapy is limited to 60 visits combined per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits combined per benefit period.</i></p>		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office  Outpatient Hospital	\$25/\$35 copay per visit medical deductible does not apply  20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<b>Pulmonary rehabilitation</b> <i>Coverage is unlimited visits per benefit period.</i>  Office  Outpatient Hospital	\$25/\$35 copay per visit medical deductible does not apply  20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<b>Cardiac rehabilitation</b> <i>Coverage is unlimited visits per benefit period.</i>  Office  Outpatient Hospital	\$25/\$35 copay per visit medical deductible does not apply  20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<b>Dialysis/Hemodialysis</b>  Office  Outpatient Hospital	\$25/\$35 copay per visit medical deductible does not apply  20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met  50% coinsurance after medical deductible is met
<b>Chemo/Radiation Therapy</b>  Office	\$25/\$35 copay per visit medical deductible does not apply <sup>‡</sup>	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<b>Skilled Nursing Care (facility)</b> <i>Coverage for Skilled Nursing is limited to 90 days per benefit period.</i>	\$200 per admission	50% coinsurance after medical deductible is met
<b>Inpatient Hospice</b>	No charge	No charge
<b>Durable Medical Equipment</b>	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
<b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Pharmacy Deductible</b>	Not applicable	Not applicable
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
<b>Prescription Drug Coverage</b> <b>Network: Base Network</b> <b>Drug List: Select Drugs not included on the Select drug list will not be covered.</b>		
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> 30 day supply (cost shares noted below) <b>Retail 90 Pharmacy</b> 90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies). <b>Home Delivery Pharmacy</b> 90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail. You will need to call us on the number on your ID card to sign up when you first use the service. <b>Specialty Pharmacy</b> 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.		
<b>Tier 1 - Typically Generic</b>	\$10 copay per prescription (retail) and \$20 copay per prescription (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Tier 2 – Typically Preferred Brand</b>	\$40 copay per prescription (retail) and \$80 copay per prescription (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b>	\$75 copay per prescription (retail) and \$150 copay per prescription (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
<b>Tier 4 – Typically Specialty (brand and generic)</b>	\$150 copay per prescription (30-day supply)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out of pocket limit.</i>		
<b>Children's Vision Essential Health Benefits (up to age 19)</b>		
<b>Vision exam</b> <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$30
<b>Frames</b> <i>Limited to 1 unit per benefit period.</i>	No charges	Reimbursed Up to \$45
<b>Lenses</b> <i>Limited to 1 unit per benefit period combined with OON Coverage. OON Reimbursement: Single Reimbursed Up to \$25, Bifocal Reimbursed Up to \$40, Trifocal Reimbursed Up to \$55.</i>	No charge	Receives Reimbursement
<b>Elective Contact Lenses</b> <i>Limited to 1 unit per benefit period.</i>	No charge	Reimbursed Up to \$60
<b>Non-Elective Contact Lenses</b> <i>Limited to 1 unit per benefit period.</i>	No charge	Reimbursed Up to \$210

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<i>This is a brief outline of your dental coverage. Only children's dental services count towards your out of pocket limit.</i>		
<b>Children's Dental Essential Health Benefits</b> <b>Diagnostic and preventive</b> <i>Limited to 2 visits per 12 months.</i>	No charge	No charge

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Basic services</b>	20% coinsurance deductible does not apply	20% coinsurance deductible does not apply
<b>Major services</b>	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply
<b>Medically Necessary Orthodontia services</b>	50% coinsurance deductible does not apply	50% coinsurance deductible does not apply
<b>Cosmetic Orthodontia services</b>	Not covered	Not covered
<b>Adult Dental</b>	Not covered	Not covered

**Notes:**

- Dependent Age Limit: to the end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- ‡ You will pay the PCP's office visit copay when services are provided in their office.

*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 Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.*

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Questions: (833) 578-4441 or visit us at [www.anthem.com](http://www.anthem.com)



## 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 (833) 578-4441

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 (833) 578-4441

**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՝ (833) 578-4441:

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**Navajo (Diné):** Díí naaltsoos biká'ígíí lahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níl hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojì' hodiilnih (833) 578-4441.

## Language Access Services:

**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: (833) 578-4441.

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### 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>.