

# Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Anthem Blue Access PPO HSAs Option

Your Network: Blue Access

*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.*

*This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.*

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b> <i>See notes section to understand how your deductible works.</i>	\$3,000 person / \$6,000 family	\$3,000 person / \$6,000 family
<b>Out-of-Pocket Limit</b> <i>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.</i>	\$5,000 person / \$10,000 family	\$10,000 person / \$20,000 family
<b>Preventive care/screening/immunization</b> <i>In-network preventive care is not subject to deductible, if your plan has a deductible.</i>	No charge	40% coinsurance after deductible is met
<b>Doctor Home and Office Services</b>  <b>Primary Care Visit to treat an injury or illness</b>  LiveHealth Online	20% coinsurance after deductible is met  \$59 copay	40% coinsurance after deductible is met
<b>Specialist Care Visit</b>	20% coinsurance after deductible is met	40% 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
<p><b>Prenatal and Post-natal Care</b>  <i>In-Network preventive prenatal services are covered at 100%.</i></p>	<p>20% coinsurance after deductible is met <b>-Inpatient Hospital</b></p>	<p>40% coinsurance after deductible is met</p>
<p><b>Other Practitioner Visits:</b></p> <p>Retail Health Clinic</p> <p>On-line Visit</p> <p>Manipulation Therapy-Chiropractic  <i>Coverage is limited to 26 visits per benefit period. Visit limits are combined both across outpatient and other professional visits.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Other Services in an Office:</b></p> <p>Allergy Testing</p> <p>Chemo/Radiation Therapy</p> <p>Dialysis/Hemodialysis</p> <p>Prescription Drugs  <i>For the drugs itself dispensed in the office through infusion/injection.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>



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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Emergency and Urgent Care</b></p> <p><b>Urgent Care (Office Setting)</b></p> <p><b>Urgent care(Facility Setting)</b></p> <p><b>Urgent Care: Facility fees</b></p> <p><b>Urgent Care: Doctor and other services</b></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b>Emergency Room Facility Services</b></p> <p><b>Emergency Room Doctor and Other Services</b></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b>Ambulance (Air, Ground, and Water)</b></p>	<p>20% coinsurance after deductible is met</p>	<p>Covered as In-Network</p>
<p><b>Outpatient Mental/Behavioral Health and Substance Abuse</b></p> <p><b>Doctor Office Visit</b></p> <p><b>Facility visit:</b></p> <p>    Facility Fees</p> <p>    Doctor Services</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Outpatient Surgery</b></p> <p><b>Facility Fees:</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p><b>Doctor and Other Services:</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)</b></p> <p><b>Facility fees (for example, room &amp; board)</b>  <i>Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs is limited to 60 days combined per benefit period. Limit is combined In-Network and Non-Network.</i></p> <p><b>Human Organ and Tissue Transplants</b>  <i>Acquisition and transplant procedures, harvest and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i></p> <p><b>Doctor and other services</b></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Recovery &amp; Rehabilitation</b></p> <p><b>Home Health Care</b>  <i>Coverage is limited to 100 visits per benefit period. Limit is combined In-Network and Non-Network.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Rehabilitation services (for example, physical/speech/occupational therapy):</b></p> <p><b>Office</b>  <i>Coverage for Occupational Therapy and Physical Therapy is limited to 44 visits per benefit period combined, and Speech Therapy is limited to 20 visits per benefit period. Coverage for Occupational Rehabilitation services, Physical Rehabilitation and Manipulation Therapy services is limited to 44 visits per benefit period. Limit excludes manipulation therapy by a Chiropractor. Limit is combined In-Network and Non-Network across professional and outpatient visits. Visit limits are combined both across outpatient and other professional visits.</i></p> <p><b>Outpatient Hospital</b>  <i>Coverage for Occupational Therapy and Physical Therapy is limited to 44 visits per benefit period combined, and Speech Therapy is limited to 20 visits per benefit period. Coverage for Occupational Rehabilitation services, Physical Rehabilitation and Manipulation Therapy services is limited to 44 visits per benefit period. Limit excludes manipulation therapy by a Chiropractor. Limit is combined In-Network and Non-Network across professional and outpatient visits. Visit limits are combined both across outpatient and other professional visits.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Cardiac rehabilitation</b></p> <p><b>Office</b>  <i>Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i></p> <p><b>Outpatient Hospital</b>  <i>Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both</i></p>	20% coinsurance after deductible is met	40% 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
<i>across outpatient and other professional visits.</i>		
<p><b>Pulmonary rehabilitation</b></p> <p>Office <i>Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i></p> <p>Outpatient Hospital <i>Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><b>Skilled Nursing Care (in a facility)</b> <i>Coverage is limited to 100 days per benefit period. Limit is combined In-Network and Non-Network.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Hospice</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p><b>Prosthetic Devices</b> <i>Coverage for wigs needed after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

# Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Pharmacy Deductible</b>	Combined with medical deductible	Combined with medical deductible
<b>Pharmacy Out of Pocket</b>	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
<b>Prescription Drug Coverage</b> <i>Essential Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.</i>	PreventiveRX	
<b>Tier 1 - Typically Generic</b> <i>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.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 2 – Typically Preferred Brand</b> <i>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.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b> <i>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.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met (retail) and Not covered (home delivery)



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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Tier 4 - Typically Specialty (brand and generic)</b> <i>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.</i></p>	20% coinsurance after deductible is met	Not Covered

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## Notes:

- Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent age: to end of the year in which the child attains age 26.
- 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.
- Certain diabetic and asthmatic supplies are available at Network pharmacies, diabetic test strips paid same as any other drug.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- 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.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- If office visit is a coinsurance, the coinsurance also applies to allergy injections.
- Certain diabetic and asthmatic supplies are covered subject to applicable prescription drug copayments/coinsurance when you get them from an In network pharmacy. These supplies are covered as medical supplies and durable medical equipment if you get them from an Out of network pharmacy. Diabetic test strips are covered subject to applicable prescription drug copayment/coinsurance. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.
- DME - 20% coinsurance for Network/40% Non-Network Durable Medical Equipment, Medical Supplies, Orthotics, Asthma Supplies, and Phenylketonuria (PKU). Excludes Prosthetics, Diabetic Supplies and Mastectomy prostheses which will apply the plan's cost shares.
- Hospital stay for Maternity Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- The Rx option includes the Essential formulary.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.
- SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice. Specialist (SCP) copayment is applicable to all Specialists (excludes: General Physicians, Internists, Pediatricians, OB/Gyns, Geriatrics, Physical Therapy, Occupational Therapy or any other Network provider as allowed by the plan).
- Immunization through age 5 – No Cost Share up to the maximum allowable amount (Network).
- Benefits are limited to abortions performed to preserve the life of the female upon whom the abortion is performed. Elective abortions are not a Covered Service.

In Missouri, (excluding 30 counties in the Kansas City area) Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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- If you get Covered Services in an office setting from a Physical therapist or Occupational Therapist, you will not have to pay an office visit Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.
- All covered expenses accumulate separately toward the preferred or non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Deductible amount.
- All covered expenses accumulate separately toward the preferred or non-preferred Out-of-Pocket Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Out-of-Pocket Limit. Pharmacy expenses apply towards the Out-of-Pocket Limit. The family Out-of-Pocket Limit is a cumulative Out-of-Pocket Limit for all family members. The family Out-of-Pocket Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Limit amount.

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