Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Anthem Blue Essential Open Access POS OAP12 2500/30%/7900 L

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 Certificate of Coverage. If there is a difference between this summary and the Certificate of Coverage the Certificate of Coverage 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.*	$2,500 person / $7,500 family	$7,500 person / $22,500 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 your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$7,900 person / $15,800 family	$23,700 person / $47,400 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	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Office Visit to treat an injury or illness	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Surgery Performed by a Primary Care Physician/Specialist	30% coinsurance after deductible is met	50% coinsurance after deductible is met

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Specialist Care Visit *All services performed in the office are included in the office copay*	$60 copay per visit deductible does not apply	50% coinsurance after deductible is met
Maternity Physician Services *Global obstetrical care (prenatal, delivery, and postpartum services.)*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
On-line Medical Visit	No charge for the first 12 visits and then $30 per visit deductible does not apply	50% coinsurance after deductible is met
Chiropractic/Manipulation Therapy	Not covered	Not covered
Acupuncture	Not covered	Not covered
Other Services in an Office:		
Allergy Testing	Not covered	Not covered
Chemo/Radiation Therapy	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs	30% coinsurance after deductible is met	50% coinsurance after deductible is met

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Diagnostic Services		
Lab:		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met

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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. Non-Emergency use of Emergency Room Services is Not Covered.*	$350 copay per visit and 30% coinsurance deductible does not apply	Covered as In-Network
Ambulance (Air, Ground, and Water)	30% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility visit:		
Facility Fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	$150 copay per visit and 30% coinsurance deductible does not apply	50% coinsurance after deductible is met

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Doctor and Other Services:		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	30% 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 combined In-Network Providers and Non-Network Provides combined is limited to 60 days per year.*	$500 copay per admission and 30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Doctor and other services	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Care Visits *Coverage is limited to 100 visit(s) 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.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office	Not covered	Not covered
Outpatient Hospital	Not covered	Not covered

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Cardiac rehabilitation		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% 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 year.*	$500 copay per admission and 30% coinsurance deductible does not apply	50% coinsurance after deductible is met
Hospice	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment *Coverage for hearing aids services is limited to $3,000 per ear per 48 Months. Limit is combined In-Network and Non-Network. Covered through the age of 18.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices ~~*Coverage for Wigs after cancer treatment is limited to 1 item per year. Limit is combined In-Network and Non-Network.*~~	30% 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	$500 person / $1,000 family	$500 person / $1,000 family
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
Tier 1 - 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.*	$15 copay per prescription, Pharmacy deductible does not apply (retail only). $15 copay per prescription, Pharmacy deductible does not apply (home delivery only).	$15 copay per prescription, Pharmacy 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.*	$40 copay per prescription after Pharmacy deductible is met (retail only). $80 copay per prescription after Pharmacy deductible is met (home delivery only).	$40 copay per prescription after Pharmacy deductible is met (retail only).

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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.*	$75 copay per prescription after Pharmacy deductible is met (retail only). $225 copay per prescription after Pharmacy deductible is met (home delivery only).	$75 copay per prescription after Pharmacy 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.*	25% coinsurance up to $350 per prescription after Pharmacy deductible is met (retail and home delivery).	25% coinsurance up to $350 per prescription after Pharmacy deductible is met (retail only).

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Notes:

- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to 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 out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- When using out-of-network providers, members are responsible for any difference between the Maximum Allowed Amount and the amount the provider actually charges, as well as any copayments, deductibles and/or applicable coinsurance.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits. Facilities considered In-Network are BDC/CME facilities; all others would apply as plan Out-of-Network benefits according to the plan design.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs are not covered.
- Removal/extraction of impacted teeth is not covered.
- Private Duty Nursing is not covered.
- Care or treatment that is not medically necessary is not covered.
- Cosmetic surgery is not covered, except to restore function altered by disease or trauma
- Dental care and oral surgery; except for accidental injury to natural teeth, treatment of TMJ and radiation for head and neck cancer are not covered.
- Occupational related illness or injury is not covered.
- Treatment, drugs or supplies considered experimental or investigational are not covered.
- For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".

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) 397-9267

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 (855) 397-9267 .

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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 (855) 397-9267.

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