

Your summary of benefits



Anthem® Blue Cross

Your Contract Code: 5B6F

Your Plan: CEWW-Anthem PPO Copay Deductible and Coinsurance -Platinum II

Your Network: PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	No charge

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$250 person / \$750 family	\$250 person / \$750 family
Overall Out-of-Pocket Limit <i>The out-of-pocket costs you pay for prescription drugs obtained at a pharmacy will apply to a separate Pharmacy Out-of-Pocket Limit. See the Covered Prescription Drug Benefits section.</i>	\$750 person / \$2,250 family	\$750 person / \$2,250 family
<p>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.</p> <p>All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit.</p> <p>The In-Network and Non-Network deductibles and out-of-pocket are combined and accumulate toward each other.</p>		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
Primary Care (PCP) <i>virtual and office</i>	10% coinsurance after deductible is met	10% coinsurance after deductible is met
Mental Health and Substance Use Disorder Services <i>virtual and office</i>	10% coinsurance after deductible is met	10% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	10% coinsurance after deductible is met	10% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Other Practitioner Visits</u></p> <p>Routine Maternity Care (Prenatal and Postnatal)</p> <p>Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p> <p>Chiropractic Services</p> <p>Acupuncture</p>	<p>No charge</p> <p>10% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>No charge</p>	<p>100% up to the allowed amount</p> <p>100% up to the allowed amount</p> <p>20% coinsurance after deductible is met</p> <p>100% up to the allowed amount</p>
<p><u>Other Services in an Office</u></p> <p>Allergy Testing</p> <p>Prescription Drugs <i>Dispensed in the office</i></p> <p>Surgery</p>	<p>20% coinsurance after deductible is met</p> <p>No charge</p> <p>No charge</p>	<p>20% coinsurance after deductible is met</p> <p>100% up to the allowed amount</p> <p>100% up to the allowed amount</p>
<p>Preventive care / screenings / immunizations</p>	<p>No charge</p>	<p>100% up to the allowed amount</p>
<p>Preventive Care for Chronic Conditions <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>100% up to the allowed amount</p>
<p><u>Diagnostic Services</u></p> <p>Lab</p> <p>Office</p> <p>Freestanding Lab/Reference Lab</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p> <p>\$30 copay per visit deductible does not apply</p>	<p>100% up to the allowed amount</p> <p>100% up to the allowed amount</p> <p>100% up to the allowed amount</p>
<p>X-Ray</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>\$30 copay per visit deductible does not apply</p>	<p>100% up to the allowed amount</p> <p>100% up to the allowed amount</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>\$30 copay per visit deductible does not apply</p>	<p>100% up to the allowed amount</p> <p>100% up to the allowed amount</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p>Emergency Room Facility Services <i>Your copay will be waived if admitted.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance</p>	<p>No charge</p> <p>\$100 copay per visit deductible does not apply</p> <p>No charge</p> <p>No charge</p>	<p>100% up to the allowed amount</p> <p>Covered as In-Network</p> <p>100% up to the allowed amount</p> <p>100% up to the allowed amount</p>
<p>Outpatient Mental Health and Substance Use Disorder Services at a Facility</p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>No charge</p> <p>No charge</p>	<p>100% up to the allowed amount</p> <p>100% up to the allowed amount</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Physician and other services <i>including surgeon fees</i></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>100% up to the allowed amount</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></p> <p>Facility Fees</p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>No charge</p> <p>No charge</p>	<p>100% up to the allowed amount</p> <p>100% up to the allowed amount</p>
<p>Home Health Care</p> <p>Visits 1-40</p> <p>Visits 41-325</p>	<p>No charge</p> <p>20% coinsurance after deductible is met</p>	<p>100% up to the allowed amount</p> <p>20% coinsurance after deductible is met</p>
<p>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>No charge</p>	<p>100% up to the allowed amount</p> <p>100% up to the allowed amount</p>
<p>Pulmonary rehabilitation <i>office and outpatient hospital</i></p>	<p>No charge</p>	<p>100% up to the allowed amount</p>
<p>Cardiac rehabilitation <i>office and outpatient hospital</i></p>	<p>No charge</p>	<p>100% up to the allowed amount</p>
<p>Dialysis/Hemodialysis <i>office and outpatient hospital</i></p>	<p>No charge</p>	<p>100% up to the allowed amount</p>
<p>Chemo/Radiation Therapy <i>office and outpatient hospital</i></p>	<p>No charge</p>	<p>100% up to the allowed amount</p>
<p>Skilled Nursing Care (facility) <i>Coverage is limited to 200 days per year.</i></p>	<p>No charge</p>	<p>100% up to the allowed amount</p>
<p>Inpatient Hospice</p>	<p>No charge</p>	<p>100% up to the allowed amount</p>
<p>Durable Medical Equipment</p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>
<p>Prosthetic Devices</p>	<p>No charge</p>	<p>20% coinsurance after deductible is met</p>

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not covered
Pharmacy Out-of-Pocket Limit	\$500 person / \$1,500 family	Not covered
Prescription Drug Coverage Network: <i>Base Network</i> Drug List: <i>National</i>		
Day Supply Limits: Retail Pharmacy 30 day supply (cost shares noted below) Retail 90 Pharmacy 90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies). Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service. Specialty Pharmacy 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.		
Tier 1 - Typically Generic	\$5 copay per prescription (retail) and \$10 copay per prescription (home delivery)	Not covered
Tier 2 – Typically Preferred Brand	\$30 copay per prescription (retail) and \$60 copay per prescription (home delivery)	Not covered
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs	\$60 copay per prescription (retail) and \$120 copay per prescription (home delivery)	Not covered

Notes:

- 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.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.

- Covered Infertility services: lab and radiology tests, cryopreservation, fertility drugs, surgical treatments such as: Artificial Insemination, In-vitro fertilization (IVF), GIFT, ZIFT. Cost share will be applied based on service and setting. Lifetime Maximum: IVF limited to 3 cycles.

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: Visit us at www.anthem.com

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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) 241-7085

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) 241-7085

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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 nił hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiłlnih (844) 241-7085.

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