

Your summary of benefits



Anthem® Blue Cross

CEWW

Your Plan: Anthem PPO Copay Deductible and Coinsurance – Platinum I

Your Network: PPO

Out-of-Network Reimbursement rate: 150% of National Medicare

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	20% coinsurance
Mental Health & Substance Use Disorder Services	20% coinsurance
Specialist care	20% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$0 person / \$0 family	\$0 person / \$0 family
Overall Out-of-Pocket Limit	\$50 person / \$100 family	\$50 person / \$100 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. There is a separate Pharmacy deductible and out of pocket limit noted below.</p> <p>In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not 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>	20% coinsurance	20% coinsurance
Mental Health and Substance Use Disorder Services <i>virtual and office</i>	20% coinsurance	20% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist Care <i>virtual and office</i>	20% coinsurance	20% coinsurance
<u>Other Practitioner Visits</u> Routine Maternity Care (Prenatal and Postnatal) Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i> Chiropractic Services Acupuncture	Covered in Full 20% coinsurance 20% coinsurance Covered in Full	100% of allowed amount 20% coinsurance 20% coinsurance 100% of allowed amount
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs <i>Dispensed in the office</i> Surgery	20% coinsurance Covered In Full Covered In Full	20% coinsurance 100% of allowed amount 20% coinsurance
Preventive care / screenings / immunizations	Covered In Full	100% of allowed amount
<u>Diagnostic Services</u> Lab Office Freestanding Lab/Reference Lab Outpatient Hospital	Covered In Full Covered In Full Covered In Full	100% of allowed amount 100% of allowed amount 100% of allowed amount
X-Ray Office Outpatient Hospital	Covered In Full Covered In Full	100% of allowed amount 100% of allowed amount
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office	Covered In Full	100% of allowed amount

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	Covered In Full	100% of allowed amount
<p><u>Emergency and Urgent Care</u> Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p>Emergency Room Facility Services</p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance</p>	<p>Covered In Full</p> <p>Covered In Full</p> <p>Covered In Full</p> <p>Covered In Full</p> <p>Covered In Full</p>	<p>100% of allowed amount</p> <p>100% of allowed amount</p> <p>100% of allowed amount</p> <p>100% of allowed amount</p> <p>100% of 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>Covered In Full</p> <p>Covered In Full</p>	<p>100% of allowed amount</p> <p>100% of 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>Covered In Full</p> <p>Covered In Full</p> <p>Covered In Full</p> <p>Covered In Full</p> <p>Covered In Full</p>	<p>100% of allowed amount</p> <p>100% of allowed amount</p> <p>100% of allowed amount</p> <p>100% of allowed amount</p> <p>100% of allowed amount</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></p> <p>Facility Fees</p> <p>Physician and other services</p> <p>Surgeon fees</p>	<p>Covered In Full</p> <p>Covered In Full</p> <p>Covered In Full</p>	<p>100% of allowed amount</p> <p>100% of allowed amount</p> <p>100% of allowed amount</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Home Health Care <i>Visits 1 – 40</i> <i>Visits 41 – 325</i>	Covered In Full 20% coinsurance	100% of allowed amount 20% coinsurance
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> Office Outpatient Hospital	Covered In Full Covered In Full	100% of allowed amount 100% of allowed amount
Pulmonary rehabilitation Office Outpatient Hospital	Covered In Full Covered In Full	100% of allowed amount 100% of allowed amount
Cardiac rehabilitation Office Outpatient Hospital	Covered In Full Covered In Full	100% of allowed amount 100% of allowed amount
Dialysis/Hemodialysis Office Outpatient Hospital	Covered In Full Covered In Full	100% of allowed amount 100% of allowed amount
Chemo/Radiation Therapy Office Outpatient Hospital	Covered In Full Covered In Full	100% of allowed amount 100% of allowed amount
Skilled Nursing Care (facility) <i>Coverage is limited to 200 days per benefit period.</i>	Covered In Full	100% of allowed amount
Inpatient Hospice	Covered In Full	100% of allowed amount
Durable Medical Equipment	Covered In Full	20% coinsurance

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	Covered In Full	20% coinsurance
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible <i>Home Delivery is not subject to deductible.</i>	\$50 person / \$125 family	Not covered
Pharmacy Out-of-Pocket Limit	\$400 person / \$1,200 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. 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	\$7.50 per prescription (retail), \$15 copay per maintenance prescription (home delivery)	Not covered
Tier 2 – Typically Preferred Brand	\$25 copay per prescription (retail), \$16 copay per maintenance prescription (home delivery)	Not covered
Tier 3 - Typically Non-Preferred Brand	\$40 copay per prescription (retail), \$16 copay per maintenance prescription (home delivery)	Not covered

Tier 4 - Specialty Drugs	\$60 copay per prescription	Not covered
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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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