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	Covered In Full
Mental Health & Substance Use Disorder Services	Covered In Full
Specialist care	Covered In Full

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	$750 person / $2,250 family	$750 person / $2,250 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. There is a separate Pharmacy deductible and out of pocket limit noted below. The In-Network and Non-Network deductibles and out-of-pocket are combined and accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) *virtual and office*	10% coinsurance after deductible is met	10% coinsurance after deductible is met
Mental Health and Substance Use Disorder Services *virtual and office*	10% coinsurance after deductible is met	10% coinsurance after deductible is met
Specialist Care *virtual and office*	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
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	Covered In Full	100% up to the allowed amount
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	10% coinsurance after deductible is met	100% up to the allowed amount
Chiropractic Services	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Acupuncture	Covered In Full	100% up to the allowed amount
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	Covered In Full	100% up to the allowed amount
Surgery	Covered In Full	100% up to the allowed amount
Preventive care / screenings / immunizations	Covered In Full	100% up to the allowed amount
Preventive Care for Chronic Conditions *per IRS guidelines*	Covered In Full	100% up to the allowed amount
Diagnostic Services **Lab**		
Office	Covered In Full	100% up to the allowed amount
Freestanding Lab/Reference Lab	Covered In Full	100% up to the allowed amount
Outpatient Hospital	$30 copay per visit deductible does not apply	100% up to the allowed amount
X-Ray		
Office	Covered In Full	100% up to the allowed amount
Outpatient Hospital	$30 copay per visit deductible does not apply	100% up to the allowed amount

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	Covered In Full	100% up to the allowed amount
Outpatient Hospital	$30 copay per visit deductible does not apply	100% up to the allowed amount
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	Covered In Full	100% up to the allowed amount
Emergency Room Facility Services *Your copay will be waived if admitted.*	$100 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	Covered In Full	100% up to the allowed amount
Ambulance	Covered In Full	100% up to the allowed amount
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	Covered In Full	100% up to the allowed amount
Doctor Services	Covered In Full	100% up to the allowed amount
Outpatient Surgery		
Facility Fees		
Hospital	Covered In Full	100% up to the allowed amount
Ambulatory Surgical Center	Covered In Full	100% up to the allowed amount
Physician and other services *including surgeon fees*		
Hospital	Covered In Full	100% up to the allowed amount
Ambulatory Surgical Center	Covered In Full	100% up to the allowed amount

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	Covered In Full	100% up to the allowed amount
Physician and other services *including surgeon fees*	Covered In Full	100% up to the allowed amount
Home Health Care		
Visits 1-40	Covered In Full	100% up to the allowed amount
Visits 41-325	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.*		
Office	Covered In Full	100% up to the allowed amount
Outpatient Hospital	Covered In Full	100% up to the allowed amount
Pulmonary rehabilitation *office and outpatient hospital*	Covered In Full	100% up to the allowed amount
Cardiac rehabilitation *office and outpatient hospital*	Covered In Full	100% up to the allowed amount
Dialysis/Hemodialysis *office and outpatient hospital*	Covered In Full	100% up to the allowed amount
Chemo/Radiation Therapy *office and outpatient hospital*	Covered In Full	100% up to the allowed amount
Skilled Nursing Care (facility) *Coverage is limited to 200 days per year.*	Covered In Full	100% up to the allowed amount
Inpatient Hospice	Covered In Full	100% up to the allowed amount
Durable Medical Equipment	Covered In Full	20% coinsurance after deductible is met
Prosthetic Devices	Covered In Full	20% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	$0 person / $0 family	Not covered
Pharmacy Out-of-Pocket Limit	$750 person / $2,250 family	Not covered
Prescription Drug Coverage **Network:** ***Base Network*** **Drug List:** ***National***		
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	$7.50 copay per prescription (retail) and $15 copay per prescription (home delivery)	Not covered
Tier 2 – Typically Preferred Brand	$35 copay per prescription (retail) and $70 copay per prescription (home delivery)	Not covered
Tier 3 - Typically Non-Preferred Brand	$70 copay per prescription (retail) and $140 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.

Questions: Visit us at www.anthem.com

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(TTY/TDD: 711)

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