

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Access PPO Option 38 with Rx Option T1

Your Network: Blue Access

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$5,000 person / \$10,000 family	\$15,000 person / \$30,000 family
<b>Out-of-Pocket Limit</b>	\$6,600 person / \$13,200 family	\$19,800 person / \$39,600 family
<p>The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both 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.</p>		
<b>Preventive Care / Screening / Immunization</b>	No charge	50% coinsurance after deductible is met
<p><b><u>Doctor Home and Office Services</u></b></p> <p><b>Primary Care Visit</b> <i>When Allergy injections are billed separately by network providers, the member is responsible for a \$10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.</i></p> <p><b>Enhanced Personal Healthcare Provider Office Visit</b></p>	<p>\$35 copay per visit deductible does not apply</p> <p>\$20 copay per visit deductible does not apply</p>	<p>50% coinsurance after deductible is met</p> <p>Not Applicable</p>
<p><b>Specialist Care Visit</b> <i>When Allergy injections are billed separately by network providers, the member is responsible for a \$10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.</i></p>	\$70 copay per visit deductible does not apply	50% coinsurance after deductible is met
<b>Prenatal and Post-natal Care</b>	30% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><b><u>Other Practitioner Visits:</u></b></p> <p>Retail Health Clinic</p>	\$35 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>	\$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy <i>Coverage is limited to 12 visits per benefit period.</i>	\$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
<b><u>Other Services in an Office:</u></b>  Allergy Testing  Chemo/Radiation Therapy  Dialysis/Hemodialysis  Prescription Drugs - <i>Dispensed in the office</i>	30% coinsurance after deductible is met  \$70 copay per visit deductible does not apply <sup>†</sup>  \$70 copay per visit deductible does not apply  30% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b><u>Diagnostic Services</u></b> <b>Lab:</b>  Office  Freestanding Lab/Reference Lab  Outpatient Hospital	No charge  No charge  30% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b>X-Ray:</b>  Office  Outpatient Hospital	No charge  30% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging:</b> Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Radiology Center	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
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b>  <i>When Allergy injections are billed separately by network providers, the member is responsible for a \$10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.</i></p>	\$75 copay per visit deductible does not apply	50% coinsurance after deductible is met
<p><b>Emergency Room Facility Services</b>  <i>Copay waived if admitted.</i></p> <p><b>Emergency Room Doctor and Other Services</b></p>	<p>\$250 copay per visit and 30% coinsurance deductible does not apply</p> <p>30% coinsurance deductible does not apply</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p>
<b><u>Ambulance</u></b>	30% coinsurance after deductible is met	Covered as In-Network
<p><b><u>Outpatient Mental/Behavioral Health and Substance Abuse</u></b></p> <p><b>Doctor Office Visit</b></p> <p><b>Facility Visit:</b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$35 copay per visit deductible does not apply</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees:</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b>Doctor and Other Services:</b></p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></b></p> <p><b>Facility Fees</b></p> <p><b>Human Organ and Tissue Transplants</b> <i>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>30% coinsurance after deductible is met</p> <p>No charge</p> <p>30% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>30% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p><b>Rehabilitation services:</b></p> <p>Office <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.</i></p>	<p>\$35 copay per visit deductible does not apply</p> <p>30% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b></p> <p>Office <i>Coverage is limited to 36 visits per benefit period.</i></p>	<p>\$70 copay per visit deductible does not apply</p>	<p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital <i>Coverage is limited to 36 visits per benefit period.</i>	30% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Skilled Nursing Care (facility)</b> <i>Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.</i>	30% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Hospice</b>	No charge	No charge
<b>Durable Medical Equipment</b>	50% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Prosthetic Devices</b>	50% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Pharmacy Deductible</b>	Not applicable	Not applicable	Not applicable
<b>Pharmacy Out of Pocket</b>	Combined with In-Network medical	Combined with In-Network medical	Combined with Non-Network medical
<b>Prescription Drug Coverage</b> <i>Rx Choice Tiered Network w/R90</i> <i>Essential Drug List</i> <i>This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.</i>			
<b>Tier 1 - Typically Generic</b> <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$10 copay per prescription, deductible does not apply (retail) and \$25 copay per prescription, deductible does not apply (home delivery)	\$20 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
<b>Tier 2 – Typically Preferred Brand</b> <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	\$35 copay per prescription, deductible does not apply (retail) and \$105 copay per prescription, deductible	\$45 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
	does not apply (home delivery)		
<b>Tier 3 - Typically Non-Preferred Brand</b> 30 day supply (retail pharmacy). 90 day supply (home delivery).	\$75 copay per prescription, deductible does not apply (retail) and \$225 copay per prescription, deductible does not apply (home delivery)	\$85 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b> 30 day supply (retail pharmacy). 30 day supply (home delivery).	25% coinsurance up to \$350 per prescription, deductible does not apply (retail and home delivery)	25% coinsurance up to \$450 per prescription, deductible does not apply (retail) and Not covered (home delivery)	50% coinsurance, deductible does not apply (retail) and Not covered (home delivery)

**Notes:**

- Dependent age: to end of the month in which the child attains age 26.
- 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).
- 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.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services" which is generally coinsurance or coinsurance after your deductible is met.
- If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit or outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.
- ‡ Your cost share may be reduced when services are provided in a PCP's office.

*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.*

## Your Plan: Anthem Blue Access PPO Option 38 with Rx Option T1

### Your Network: Blue Access

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

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Questions: (833) 578-4443 or visit us at [www.anthem.com](http://www.anthem.com)

KY/LG/Anthem Blue Access PPO Option 38 with Rx Option T1/5VB3/01-01-2021

## 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 (833) 578-4443

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 (833) 578-4443.

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 578-4443:

**Chinese(中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 578-4443。

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**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 578-4443.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 578-4443.

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## Language Access Services:

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**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (833) 578-4443.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 578-4443 ਤੇ ਕਾਲ ਕਰੋ।

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### It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.