

Your summary of benefits



E J Brooks Company

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Open Access POS HSAOAP8 3500/0%/3500 PrevRx Enhanced

Your Network: Blue Open Access POS

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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Overall Deductible	\$3,500 member / \$7,000 family	\$5,000 member / \$10,000 family
Overall Out-of-Pocket Limit	\$3,500 member / \$7,000 family	\$10,000 member / \$20,000 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 member deductible and per member 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 member deductible or per member out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.		
Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	No charge after deductible is met	30% coinsurance after deductible is met
Specialist Care <i>virtual and office</i>	No charge after deductible is met	30% coinsurance after deductible is met
<u>Other Practitioner Visits</u>		
Maternity Doctor services (prenatal/postnatal care and delivery)	No charge after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Retail Health Clinic Visit <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i> Manipulation Therapy <i>Coverage is limited to 60 visits per benefit period.</i> Acupuncture	No charge after deductible is met No charge after deductible is met Not covered	30% coinsurance after deductible is met 30% coinsurance after deductible is met Not covered
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs <i>Dispensed in the office</i> Surgery	No charge after deductible is met No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance deductible does not apply
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	30% coinsurance deductible does not apply
<u>Diagnostic Services</u> Lab Office Freestanding Lab/Reference Lab Outpatient Hospital	No charge after deductible is met No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
X-Ray Office Freestanding Radiology Center Outpatient Hospital	No charge after deductible is met No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	No charge after deductible is met No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance <i>Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.</i>	No charge after deductible is met No charge after deductible is met No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility Facility Fees Doctor Services	No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Ambulatory Surgical Center Physician and other services <i>including surgeon fees</i> Hospital Ambulatory Surgical Center	No charge after deductible is met No charge after deductible is met No charge after deductible is met No charge after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u> Facility Fees Physician and other services <i>including surgeon fees</i>	 No charge after deductible is met No charge after deductible is met	 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Home Health Care <i>Limits are combined for all home health services.</i>	No charge after deductible is met	30% coinsurance after deductible is met
Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is limited to 60 visits combined per benefit period. Coverage for speech therapy is limited to 60 visits per benefit period.</i> Office Outpatient Hospital	 No charge after deductible is met No charge after deductible is met	 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Pulmonary rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 60 visits per benefit period.</i>	No charge after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i>	No charge after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis <i>office and outpatient hospital</i>	No charge after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy <i>office and outpatient hospital</i>	No charge after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per benefit period.</i>	No charge after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	No charge after deductible is met	30% coinsurance after deductible is met
Durable Medical Equipment	No charge after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	No charge after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits		Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Hearing Aids <i>Coverage is limited to 1 item per hearing-impaired ear up to \$3,000 per ear, every 48 months for members through age 18.</i>		No charge after deductible is met	30% coinsurance after deductible is met
Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with In-Network medical deductible	Combined with Out-of-Network medical deductible
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Out-of-Network medical out-of-pocket limit
Prescription Drug Coverage Network: <i>RX Choice Tiered Network</i> Drug List: <i>National Direct Plus</i>			
Day Supply Limits: Retail Pharmacy 30 day supply (cost shares noted below) Retail 90 Pharmacy 90 day supply (follow home delivery cost share amounts noted below) Home Delivery Pharmacy 90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery 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 or an In-Network Pharmacy that carries your specialty drug.			
Preventive Drugs No deductible, copayment or coinsurance applies to prescription drugs on the PreventiveRx Enhanced drug list when you use a Preferred Network or In-Network Pharmacy.			
Tier 1 - Typically Generic	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail only)
Tier 2 - Typically Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail only)
Tier 3 - Typically Non-Preferred Brand	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail only)
Tier 4 - Typically Specialty (brand and generic)	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail and home delivery)	0% coinsurance after deductible is met (retail only)

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.
- 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.
- When using an Out-of-Network Pharmacy, members are responsible for the stated copay & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.

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.

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Questions: (855) 397-9267 or 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 (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

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՝ (855) 397-9267:

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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 (855) 397-9267.

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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 níl hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo koj' hodiłlnih (855) 397-9267.

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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: (855) 397-9267.

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