# Your summary of benefits

Anthem

Anthem® Blue Cross and Blue Shield

Your Plan: E J BROOKS COMPANY: Anthem Blue Open Access POS HSAOAP8 3500/10%/4000 AE Prev Rx

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** | 10% 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 |
|---|---|---|
| **Overall Deductible** | $3,500 member / $7,000 family | $5,000 member / $10,000 family |
| **Overall Out-of-Pocket Limit** | $4,000 member / $8,000 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.<br>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).<br>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)** *You are encouraged to select a Primary Care Physician (PCP).* | | |
| **Primary Care (PCP)** *virtual and office* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Mental Health and Substance Use Disorder Services** *virtual and office* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Specialist Provider** *virtual and office* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Other Practitioner Visits** | | |
| **Maternity Doctor services** (prenatal/postpartum care and delivery) | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Retail Health Clinic Visit** *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.* | 10% 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 |
|---|---|---|
| **Manipulation Therapy** *Coverage for manipulation, physical, occupational, speech, and pulmonary therapies is limited to 60 visits per benefit period.* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Acupuncture** | Not covered | Not covered |
| **Other Services in an Office** | | |
| **Allergy Testing** | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Prescription Drugs** *Dispensed in the office* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Surgery** | 10% 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** *per IRS guidelines* | No charge | Cost share is based on the setting services are received. |
| **Diagnostic Services Lab** | | |
| Office | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Freestanding Lab/Reference Lab | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Outpatient Hospital | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Diagnostic Services X-Ray** | | |
| Office | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Freestanding Radiology Center | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Outpatient Hospital | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Diagnostic Services Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | | |
| Office | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Freestanding Radiology Center | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Outpatient Hospital | 10% 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 |
|---|---|---|
| **Emergency and Urgent Care** | | |
| **Urgent Care** *includes doctor services. Additional charges may apply depending on the care provided.* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Emergency Room Facility Services**<br>*Your coinsurance and deductible will be waived if admitted.* | 10% coinsurance after deductible is met | Covered as In-Network |
| **Emergency Room Doctor and Other Services** | 10% coinsurance after deductible is met | Covered as In-Network |
| **Ambulance**<br>*Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip. The $50,000 limit does not apply to air ambulance services.* | 10% coinsurance after deductible is met | Covered as In-Network |
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | | |
| **Facility Fees** | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Doctor Services** | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Outpatient Surgery** | | |
| **Facility Fees** | | |
| Hospital | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Ambulatory Surgical Center | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Physician and other services** *including surgeon fees* | | |
| Hospital | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Ambulatory Surgical Center | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)** | | |
| **Facility Fees** | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Physician and other services** *including surgeon fees* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Home Health Care**<br>*Limits are combined for all home health services.* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Therapy Services** | | |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.*<br>*Coverage for manipulation, physical, occupational, speech, and pulmonary therapies is limited to 60 visits combined per benefit period* | | |
| Office | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| Outpatient Hospital | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Pulmonary rehabilitation** *office and outpatient hospital*<br>*Coverage for manipulation, physical, occupational, speech, and pulmonary therapies is limited to 60 visits combined per benefit period* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Cardiac rehabilitation** *office and outpatient hospital*<br>*Coverage is limited to 36 visits per benefit period.* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Dialysis/Hemodialysis** *office and outpatient hospital* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Chemo/Radiation Therapy** *office and outpatient hospital* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Skilled Nursing Care (facility)**<br>*Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Inpatient Hospice** | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Additional Services, Equipment and Devices** | | |
| **Durable Medical Equipment** | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Prosthetic Devices** | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Wigs**<br>*Coverage for wigs is limited to 1 item per benefit period.* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Hearing Aids**<br>*Coverage is limited to 1 item per hearing-impaired ear up to $3,000 per ear, every 48 months for members through age 18.* | 10% coinsurance 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 |

| 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 |
|---|---|---|---|
| **Prescription Drug Coverage**<br>**Network: Rx Choice Tiered Network**<br>**Drug List: National Direct Preferred** If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. ***For more information, refer to "National Direct Preferred Drug List" at*** *https://www.anthem.com/pharmacy-information/.* | | | |
| **Day Supply Limits**<br>**Retail Pharmacy:** *30 day supply (cost shares noted below)*<br>**Retail 90 Pharmacy:** *90 day supply (follow home delivery cost share amounts noted below)*<br>**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.*<br>**Specialty Pharmacy:** *30 day supply at retail (cost shares noted below 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. Drug cost share assistance programs may be available for certain specialty drugs.* | | | |
| **Preventive Drugs:** *No deductible, copayment or coinsurance applies to prescription drugs on the PreventiveRx Enhanced drug list when you use a Preferred Network or an In-Network Pharmacy.* | | | |
| **Tier 1 - Typically Generic** | 10% coinsurance after deductible is met (retail and home delivery) | 10% coinsurance after deductible is met (retail only) | 10% coinsurance after deductible is met (retail only) |
| **Tier 2 - Typically Preferred Brand** | 10% coinsurance after deductible is met (retail and home delivery) | 10% coinsurance after deductible is met (retail only) | 10% coinsurance after deductible is met (retail only) |
| **Tier 3 - Typically Non-Preferred Brand** | 10% coinsurance after deductible is met (retail and home delivery) | 10% coinsurance after deductible is met (retail only) | 10% coinsurance after deductible is met (retail only) |
| **Tier 4 - Typically Specialty (brand and generic)** | 10% coinsurance after deductible is met (retail and home delivery) | 10% coinsurance after deductible is met (retail only) | 10% 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.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full after deductible 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.
- 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

Anthem

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## We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document

**Spanish**
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

**Chinese**
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

**Vietnamese**
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

**Korean**
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

**Tagalog**
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

**Russian**
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

**French Creole**
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

**Arabic**
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

**French**
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

**Persian**
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

**Armenian**
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

**Japanese**
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

**Italian**
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

**German**
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

**Polish**
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

**Pennsylvania Dutch**
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

**TTY/TTD:711**

### It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf