

Your summary of benefits



Anthem® Blue Cross

Your Plan: Custom Anthem PPO HSA 3000/20

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible <i>The deductible for In-Network and Non-Network are added separately and do not apply towards each other.</i>	\$3,000 person / \$6,000 family	\$3,000 person / \$6,000 family
Out-of-Pocket Limit <i>The Out-of-Pocket limit for In-Network and Non-Network are added separately and do not apply towards each other.</i>	\$5,000 person / \$10,000 family	\$10,000 person / \$20,000 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>		
Preventive Care / Screening / Immunization	No charge deductible does not apply	40% coinsurance after deductible is met
<u>Doctor Home and Office Services</u>		
Primary Care Visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care Visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prenatal and Post-natal Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Practitioner Visits:</u>		
Retail Health Clinic	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Preferred On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>	\$10 copay per visit after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy <i>Coverage for In-Network and Non-Network is limited to 24 visits per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Acupuncture <i>Coverage for In-Network and Non-Network is limited to 20 visits per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Services in an Office:</u> Allergy Testing Chemo/Radiation Therapy Dialysis/Hemodialysis Prescription Drugs - <i>Dispensed in the office</i> <i>Maximum of \$250 member per visit member cost share per drug.</i>	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab: Office Freestanding Lab Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
X-Ray: Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
Advanced Diagnostic Imaging: Office Freestanding Radiology Center Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</p> <p>Emergency Room Facility Services <i>Copay waived if admitted.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance</p>	<p>20% coinsurance after deductible is met</p> <p>\$100 copay then 20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><u>Outpatient Mental/Behavioral Health and Substance Abuse</u></p> <p>Doctor Office Visit</p> <p>Facility visit:</p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees:</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services:</p> <p>Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><u>Hospital (including Maternity, Mental / Behavioral Health, Substance Abuse):</u></p> <p>Facility fees</p> <p>Doctor and other services</p>	<p>\$100 copay per admission then 20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>\$100 copay per admission then 40% coinsurance after deductible is met</p> <p>40% 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><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage for In-Network and Non-Network is limited to 100 visits per benefit period.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Rehabilitation services:</p> <p>Office <i>Coverage for In-Network and Non-Network rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Coverage for In-Network and Non-Network rehabilitative and habilitative speech therapy combined is limited to 20 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage for In-Network and Non-Network rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per benefit period. Coverage for In-Network and Non-Network rehabilitative and habilitative speech therapy combined is limited to 20 visits per benefit period.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Cardiac rehabilitation</p> <p>Office <i>Coverage for In-Network and Non-Network is limited to 36 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage for In-Network and Non-Network is limited to 36 visits per benefit period.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Skilled Nursing Care (facility) <i>Coverage for In-Network and Non-Network Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Hospice</p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Durable Medical Equipment</p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Hearing Aids <i>Limited to 1 per ear every 3 years.</i></p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<p>Prosthetic Devices</p>	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
<p>Prescription Drug Coverage <i>National Network with R90</i> <i>This plan uses an Essential Formulary Drug List.</i> <i>This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs. Drugs not on the list are not covered.</i></p>		
<p>Preventive Drugs <i>This plan has Preventive RX coverage that allows the member designated Preventive drugs without application to Deductible or cost share.</i></p>		
Tier 1a - Typically Lower Cost Generic (Preventive Drugs)	No charge deductible does not apply	25% coinsurance up to \$250 per prescription deductible does not apply (retail) and Not covered (home deliver)
Tier 1b – Typically Generic (Preventive Drugs)	No charge deductible does not apply	25% coinsurance up to \$250 per prescription deductible does not apply (retail) and Not covered (home deliver)
Tier 2 - Typically Preferred Brand (Preventive Drugs)	No charge deductible does not apply	25% coinsurance up to \$250 per prescription deductible does not apply (retail) and Not covered (home deliver)

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 1 - Typically Lower Cost Generic 30 day supply (retail pharmacy). 90 day supply (home delivery).	\$10 copay per prescription after deductible is met (retail) and \$10 copay per prescription after deductible is met (home delivery)	25% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand 30 day supply (retail pharmacy). 90 day supply (home delivery).	\$25 copay per prescription after deductible is met (retail) and \$25 copay per prescription after deductible is met (home delivery)	25% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand 30 day supply (retail pharmacy). 90 day supply (home delivery).	\$40 copay per prescription after deductible is met (retail) and \$40 copay per prescription after deductible is met (home delivery)	25% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) 30 day supply (retail pharmacy). 30 day supply (home delivery).	30% coinsurance up to \$150 per prescription after deductible is met (retail and home delivery)	25% coinsurance up to \$250 per prescription after deductible is met (retail) and Not covered (home delivery)

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” which is generally coinsurance or coinsurance after your deductible is met.
- Anthem’s maximum payment is up to \$1,000 per day for non-emergency admissions to Non-Network Providers.
- Outpatient Facility tests and treatments are limited to \$350 per service for Non-Network Providers. Includes Diagnostic Services, X-ray, Surgery, Rehabilitation, Habilitation, and Cardiac Therapy. This also includes Surgery at Freestanding Facilities.
- Advanced Diagnostic Imaging is limited to \$800 per service for Non-Network Providers.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.

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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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