

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: USHG LLC: Blue Access EPO Copay Deductible and Coinsurance - Gold Plan

Your Network: Blue Access

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge deductible does not apply
Mental Health & Substance Use Disorder Services	No charge deductible does not apply
Specialist care	\$40 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$1,000 person / \$2,000 family	Not covered
Overall Out-of-Pocket Limit	\$3,000 person / \$6,000 family	Not covered

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.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.

Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*

Primary Care (PCP) and Mental Health and Substance Use Disorder Services <i>virtual and office</i>	\$30 copay per visit deductible does not apply	Not covered
Specialist Care <i>virtual and office</i>	\$40 copay per visit deductible does not apply	Not covered
<u>Other Practitioner Visits</u>		
Routine Maternity Care (Prenatal and Postnatal)	20% coinsurance after deductible is met	Not Applicable

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$30 copay per visit deductible does not apply	Not covered
Chiropractic Services	\$30 copay per visit deductible does not apply	Not covered
Acupuncture	Not covered	Not covered
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs <i>Dispensed in the office</i> Surgery	\$40 copay per visit deductible does not apply [†] 20% coinsurance after deductible is met \$40 copay per visit deductible does not apply [†]	Not covered Not covered Not covered
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Not covered
<u>Diagnostic Services</u> Lab Office Freestanding Lab/Reference Lab Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	Not covered Not covered Not covered
X-Ray Office Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met	Not covered Not covered
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office	20% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care includes doctor services. Additional charges may apply depending on the care provided.</p> <p>Emergency Room Facility Services Your copay will be waived if admitted.</p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance</p>	<p>\$50 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p> <p>No charge</p> <p>\$100 copay per trip</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p>Outpatient Mental Health and Substance Use Disorder Services at a Facility</p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Physician and other services</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Surgeon fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</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>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></p> <p>Facility Fees <i>Coverage for Inpatient Rehabilitation is limited to 30 days per benefit period.</i></p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Home Health Care <i>Coverage is limited to 60 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>Not covered</p>
<p>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical, occupational and speech therapies is limited to 60 visits combined per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$30 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Pulmonary rehabilitation</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$40 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$40 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<p>Dialysis/Hemodialysis <i>office and outpatient hospital</i> <i>Coverage is limited to 10 visits per benefit period. Applies to Non Network.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Chemo/Radiation Therapy <i>office and outpatient hospital</i></p>	<p>20% coinsurance after deductible is met</p>	<p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Skilled Nursing Care (facility) <i>Coverage is limited to 60 days per benefit period.</i>	20% coinsurance after deductible is met	Not covered
Inpatient Hospice	20% coinsurance after deductible is met	Not covered
Durable Medical Equipment	20% coinsurance after deductible is met	Not covered
Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	20% coinsurance after deductible is met	Not covered
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage Network: National Plus 2.0 Drug List: NPF, if you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Retail Pharmacy: up to a 34 day supply (<i>cost shares noted below</i>) Home Delivery Pharmacy: 90 day supply (<i>maximum cost shares noted below</i>) Maintenance medications are available through ESI Mail Pharmacy. <i>You will need to call us on the number on your ID card to sign up when you first use the service.</i> Specialty Pharmacy: up to a 30 day supply through Accredo. <i>Accredo may require certain drugs with special handling, provider coordination or patient education be filled by the designated specialty pharmacy. You can contact Accredo at (800) 803-2523.</i>		
Tier 1 - Typically Generic	\$10 copay per prescription (retail), \$25 copay per prescription (home delivery), and \$10 copay per prescription (specialty)	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 2 – Typically Preferred Brand	\$30 copay per prescription (retail), \$75 copay per prescription (home delivery), and \$30 copay per prescription (specialty)	Not covered
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs	\$50 copay per prescription (retail), \$125 copay per prescription (home delivery), and \$50 copay per prescription (specialty)	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.
- 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.
- ‡ You will pay the PCP's office visit copay when services are provided in their office.
- 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.

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Questions: 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 (844) 241-7085

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 (844) 241-7085

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՝ (844) 241-7085:

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(844) 241-7085。

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (844) 241-7085 تماس بگیرید.

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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 (844) 241-7085.

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 (844) 241-7085.

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(844) 241-7085 にお電話ください。

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(844) 241-7085로 문의하십시오.

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 báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo kojí' hodiilnih (844) 241-7085.

Language Access Services:

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: (844) 241-7085.

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, (844) 241-7085 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (844) 241-7085.

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It's important we treat you fairly

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