Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: USHG LLC: Blue Access PPO Copay Deductible and Coinsurance - Silver Plan

Your Network: Blue Access

Out-of-Network Reimbursement rate: 90th percentile of Fair Health

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	$50 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	$2,500 person / $5,000 family	$4,000 person / $8,000 family
Overall Out-of-Pocket Limit	$5,000 person / $10,000 family	$8,000 person / $16,000 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 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. In-Network and Non-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) and Mental Health and Substance Use Disorder Services *virtual and office*	$35 copay per visit deductible does not apply	40% coinsurance after deductible is met
Specialist Care *virtual and office*	$50 copay per visit deductible does not apply	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
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$35 copay per visit deductible does not apply	40% coinsurance after deductible is met
Chiropractic Services	$35 copay per visit deductible does not apply	40% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	$50 copay per visit deductible does not apply‡	40% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Surgery	$50 copay per visit deductible does not apply‡	40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	40% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Lab/Reference Lab	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray		
Office	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	30% 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
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$50 copay per visit deductible does not apply	40% coinsurance after deductible is met
Emergency Room Facility Services *Your copay will be waived if admitted.*	30% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	$100 copay per trip	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	No charge	40% coinsurance after deductible is met
Doctor Services	No charge	40% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Ambulatory Surgical Center	30% 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
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees *Coverage for Inpatient Rehabilitation is limited to 30 days per benefit period.*	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Physician and other services *including surgeon fees*	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Home Health Care *Coverage is limited to 60 visits per benefit period.*	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical, occupational and speech therapies is limited to 60 visits combined per benefit period.*		
Office	$35 copay per visit deductible does not apply	40% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Pulmonary rehabilitation		
Office	$50 copay per visit deductible does not apply	40% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$50 copay per visit deductible does not apply	40% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	30% 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
Skilled Nursing Care (facility) *Coverage is limited to 60 days per benefit period.*	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Inpatient Hospice	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	30% coinsurance after deductible is met	40% coinsurance after deductible is met
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 (cost shares noted below)* **Home Delivery Pharmacy:** *90 day supply (maximum cost shares noted below) Maintenance medications are available through ESI Mail 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:** *up to a 30 day supply through Accredo. 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.*		
Tier 1 - Typically Generic	$15 copay per prescription (retail), $37.50 copay per prescription (home delivery), and $15 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	$35 copay per prescription (retail), $87.50 copay per prescription (home delivery), and $35 copay per prescription (specialty)	Not covered
Tier 3 - Typically Non-Preferred Brand/Specialty Drugs	$55 copay per prescription (retail), $137.50 copay per prescription (home delivery), and $55 copay per prescription (specialty)	Not covered
Tier 4- Specialty Drugs	30% coinsurance, deductible does not apply, with no max	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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(TTY/TDD: 711)

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