Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: Anthem Blue Open Access POS HSAOAP3B 5000/20%/6900

Your Network: Blue Open Access POS

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.

This is a Health Savings Account (HSA). With this plan you can contribute pre-tax dollars to your HSA to pay for covered services. Others may also contribute dollars to your account. You can use these dollars to help meet your annual deductible. Unused dollars can be saved or invested and accumulate through retirement. Contributions to Your HSA:

For 2020, contributions can be made to your HSA up to the following:

$3,550 Individual coverage
$7,100 Family coverage

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section. The deductible for In-Network and Non-Network are added separately and do not apply towards each other.*	$5,000 member / $10,000 family	$15,000 member / $30,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of the year. See notes section for additional information regarding your out of pocket maximum. The Out-of-Pocket limit for In-Network and Non-Network are added separately and do not apply towards each other.*	$6,900 member / $13,800 family	$20,700 member / $41,400 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible. Non-Network preventive care services for children prior to their 6th birthday have no deductible.*	No charge	50% coinsurance after deductible is met

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Doctor Home and Office Services		
Primary Care Office Visit to treat an injury or illness	$30 copay per visit after deductible is met	50% coinsurance after deductible is met
Surgery Performed by a Primary Care Physician/Specialist	$60 copay per surgery after deductible is met	50% coinsurance after deductible is met
Specialist Care Visit	$60 copay per visit after deductible is met	50% coinsurance after deductible is met
Maternity Physician Services *Global obstetrical care (prenatal, delivery, and postpartum services).*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic Visit	$30 copay per visit after deductible is met	50% coinsurance after deductible is met
On-line Medical Visit	$30 copay per visit after deductible is met	50% coinsurance after deductible is met
Chiropractic/Manipulation Therapy *Coverage is limited to 20 visits per year. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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Dialysis/Hemodialysis	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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Freestanding Radiology Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care (Office Setting)	$60 copay per visit after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services *Cost share waived if admitted. Non-emergency use of Emergency Room Services is Not Covered.*	20% coinsurance after deductible is met	Covered as In-Network
Ambulance (Air, Ground, and Water)	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder		
Doctor Office Visit and Online Visit	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 60 days combined per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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Recovery & Rehabilitation		
Home Care Visits *Coverage is limited to 120 visits per benefit period. Limit is combined In-Network and Non-Network. Limit does not apply to separate Physical or Occupational or Speech Therapy limits, when performed as part of Home Health. Limits are combined for home health care and private duty nursing.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 20 visits per year. Limit is combined for In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per year. Limit is combined for In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Limits are combined with Rehabilitation office visits.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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Hospice	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs after cancer treatment is limited to 1 item per year. Coverage for wigs after cancer treatment is limited to 1 item per year. Limit is combined In-Network and Non-Network. Coverage for hearing aids services is limited to 1 item(s) per ear every 48 months for children 18 years of age or under. $3,000 maximum per hearing aid. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met

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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 maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *National Drug List* *No coverage for non-formulary drugs. Up to a 90 day supply is available at most retail pharmacies.*		
Tier 1 - Typically Generic *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$15 copay per prescription after deductible is met (retail) and $38 copay per prescription after deductible is met (home delivery)	Covered as In-Network
Tier 2 – Typically Preferred Brand *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$40 copay per prescription after deductible is met (retail) and $100 copay per prescription after deductible is met (home delivery)	Covered as In-Network
Tier 3 - Typically Non-Preferred Brand *Covers up to a 90 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).*	$80 copay per prescription after deductible is met (retail) and $200 copay per prescription after deductible is met (home delivery)	Covered as In-Network

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program).*	25% coinsurance up to $350 per prescription after deductible is met (retail and home delivery)	Covered as In-Network

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Notes:

- 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.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- When using out-of-network providers, members are responsible for any difference between the Maximum Allowed Amount and the amount the provider actually charges, as well as any copayments, deductibles and/or applicable coinsurance.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits. Facilities considered In-Network are BDC/CME facilities; all others would apply as plan Out-of-Network benefits according to the plan design.
- Routine Physical examinations necessitated by employment, foreign travel or participation in school athletic program are not covered.
- Removal/extraction of impacted teeth is not covered.
- Private Duty Nursing is not covered.
- Care of treatment that is not medically necessary is not covered.
- Cosmetic surgery is not covered, except to restore function altered by disease or trauma.
- Dental care and oral surgery; except for accidental injury to natural teeth, treatment of TMJ and radiation for head and neck cancer are not covered.
- Occupational related illness or injury is not covered.
- Treatment, drugs or supplies considered experimental or investigational are not covered.
- If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.
- Your copays, coinsurance and deductible count toward your out of pocket amount.

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