# Your summary of benefits

Anthem® Blue Cross

WSWHE

Your Plan: Anthem Blue Access PPO with HRA- Aggregate

Your Network: Blue Access

Annual HRA Contribution - $1,000 person / $2,000 family

100% Employer HRA Contribution if initial enrollment in the HRA is between 7/1 - 1/31

50% Employer HRA Contribution if initial enrollment in the HRA is between 2/1 - 6/30

| Visits with Virtual Care-Only Providers | Cost through our mobile app and website |
|---|---|
| **Primary Care, and medical services for urgent/acute care** | 10% coinsurance after deductible is met |
| **Mental Health & Substance Use Disorder Services** | 10% coinsurance 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** | $1,500 person / $3,000 family | $1,500 person / $3,000 family |
| **Overall Out-of-Pocket Limit** | $3,425 person / $6,850 family | $7,500 person / $15,000 family |
| The family deductible and out-of-pocket limit are non-embedded, meaning the cost shares of all family members apply to one family deductible and one family out-of-pocket limit. The per person deductible and per person out-of-pocket limit apply to individuals enrolled under single-only coverage.<br>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.<br>In-Network does not apply to Out-of-Network, but Out-of-Network applies to In-Network for both deductible and out-of-pocket maximum. | | |
| **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* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Specialist Care** *virtual and office* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Other Practitioner Visits**<br>**Maternity Doctor services** (prenatal/postnatal care and delivery) | 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 |
|---|---|---|
| **Retail Health Clinic** *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 |
| **Chiropractic Services** | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Acupuncture** | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **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 after deductible is met |
| **Preventive Care for Chronic Conditions** *per IRS guidelines* | No charge | 20% coinsurance after deductible is met |
| **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 |
| **X-Ray** | | |
| 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 |
| **Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | | |
| 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 |
| **Emergency and Urgent Care** | | |
| **Urgent Care** | 10% coinsurance after deductible is met | Covered as In-Network |
| **Emergency Room Facility Services** | 10% coinsurance after deductible is met | Covered as In-Network |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|---|---|---|
| **Emergency Room Doctor and Other Services** | 10% coinsurance after deductible is met | Covered as In-Network |
| **Ambulance** | 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**<br>*Coverage for Inpatient Rehabilitation is limited to 90 days per benefit period.* | 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>*Coverage is limited to 200 visits per benefit period.* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Rehabilitation and Habilitation services** *including physical, occupational, vision and speech therapies. Coverage for physical therapy is limited to 90 visits per benefit period. Coverage for speech therapy, occupational & vision is limited to 30 visits per benefit period. OON covered at 30% coinsurance after deductible is met.* | | |
| Office | 10% coinsurance after deductible is met | Covered |
| Outpatient Hospital | 10% coinsurance after deductible is met | Covered |
| **Pulmonary rehabilitation** *office and 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 |
|---|---|---|
| **Cardiac rehabilitation** *office and outpatient hospital* | 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 is limited to 120 days 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 |
| **Durable Medical Equipment** | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Prosthetic Devices**<br>*Coverage for wigs is limited to 1 item after cancer treatment per benefit period.* | 10% coinsurance after deductible is met | 30% coinsurance after deductible is met |
| **Routine Vision Benefits through Blue View Vision**<br>**Must use the BVV -Insight Network**<br>*(Every 24 months)* | $5 copay for exam<br>$115 allowance for frames<br>$10 copay for lenses<br>$75 allowance for contact lenses | Up to $30 reimbursement for exams<br>Up to $64 reimbursement for frames<br>Up to $25 reimbursement for Single vision lenses,<br>$35 for bifocal lenses, and $45 for trifocal lenses.<br>Up to $75 reimbursement for Contact lenses. |
| **Covered Prescription Drug Benefits** | **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 | Not covered |
| **Pharmacy Out-of-Pocket Limit** | Combined with In-Network medical out-of-pocket limit | Not covered |
| **Prescription Drug Coverage**<br>**Network: *Base Network***<br>**Drug List: *National*** | | |
| **Preventive Drugs** *The deductible does not apply to prescription drugs on the PreventiveRX Plus drug list when you use an In-Network Pharmacy.* | | |

| | | |
|---|---|---|
| **Day Supply Limits:**<br>**Retail Pharmacy** *30 day supply (cost shares noted below)*<br>**Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).*<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 (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.* | | |
| **Tier 1 - Typically Generic** | $10 copay per prescription after deductible is met (retail) and $20 copay per prescription after deductible is met (home delivery) | Not covered |
| **Tier 2 - Typically Preferred Brand** | $20 copay per prescription after deductible is met (retail) and $40 copay per prescription after deductible is met (home delivery) | Not covered |
| **Tier 3 - Typically Non-Preferred Brand/Specialty Drugs** | $40 copay per prescription after deductible is met (retail) and $80 copay per prescription after deductible is met (home delivery) | 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.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full 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.
- 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.*