Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Benesch, Friedlander, Coplan & Aronoff LLP-Anthem Blue Access PPO with Essential Rx Formulary on the National w/R90 Network with Optional Home Delivery

Your Network: Blue Access-Effective 01/01/2021

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$500 person / $1,000 family	$2,500 person / $5,000 family
Out-of-Pocket Limit	$2,000 person / $4,000 family	$5,000 person / $10,000 family
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.		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-natal Care	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Other Practitioner Visits:</u>		
Retail Health Clinic	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$10 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 20 visits per benefit period.*	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
<u>Other Services in an Office:</u>		
Allergy Testing	No charge	50% coinsurance after deductible is met
Chemo/Radiation Therapy - PCP	$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy - Specialist	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Dialysis/Hemodialysis	$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
X-Ray:		
Office	No charge	50% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
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
Emergency and Urgent Care		
Urgent Care *When Allergy injections are billed separately by network providers, the member is responsible for a $10 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$75 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	No charge	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$25 copay per visit deductible does not apply	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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Outpatient Surgery</u> Facility Fees: Hospital Doctor and Other Services: Hospital	 20% coinsurance after deductible is met 20% coinsurance after deductible is met	 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u> Facility fees Human Organ and Tissue Transplants *Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.* Doctor and other services	 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	 50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Recovery & Rehabilitation</u> Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	 20% coinsurance after deductible is met	 50% coinsurance after deductible is met
Rehabilitation services: Office *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined for rehabilitative and habilitative services.* Outpatient Hospital *Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined for rehabilitative and habilitative services.*	 $35 copay per visit deductible does not apply Clinical Therapeutic Intervention services: No charge 20% coinsurance after deductible is met Clinical Therapeutic Intervention services: No charge	 50% coinsurance after deductible is met 50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Cardiac rehabilitation Office *Coverage is limited to 36 visits per benefit period.* Outpatient Hospital *Coverage is limited to 36 visits per benefit period.*	$35 copay per visit deductible does not apply 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	20% coinsurance after deductible is met	50% coinsurance after deductible is met
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	20% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with In-Network medical	Combined with Non-Network medical
Prescription Drug Coverage *Essential Drug List* *National w/R90 Network*	Preventive Rx Plus listed drugs: No cost share	Preventive Rx Plus listed drugs: 50% coinsurance deductible does not apply (retail) and Not Covered (home delivery)
Tier 1 - Typically Generic *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$10 copay per prescription, deductible does not apply (retail) and $20 copay per prescription, deductible does not apply (home delivery)	50% coinsurance deductible does not apply (retail) and Not covered (home delivery)
Tier 2 – Typically Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$30 copay per prescription, deductible does not apply (retail) and $60 copay per prescription, deductible does not apply (home delivery)	50% coinsurance deductible does not apply (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *30 day supply (retail pharmacy). 90 day supply (home delivery).*	$50 copay per prescription, deductible does not apply (retail) and $100 copay per prescription, deductible does not apply (home delivery)	50% coinsurance deductible does not apply (retail) and Not covered (home delivery)

Notes:

- Dependent age: to end of the month in which the child attains age 28.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are not separate and do accumulate toward each other.
- If you have receive Urgent Care 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.
- Benefit Period – Calendar Year.

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.

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

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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 (833) 639-1634

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(TTY/TDD: 711)

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Language Access Services:

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Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'ídiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ąh ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (833) 639-1634.

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