HealthKeepers, Inc.Anthem® BlueCross and BlueShieldAnthem® BlueCross and BlueShield and its affiliate HealthKeepers, Inc.Empire BlueCross BlueShieldEmpire BlueCrossAnthem® BlueCrossAnthem® Blue Cross Life and Health Insurance CompanyBlueCross and BlueShield of GeorgiaBlueCross and BlueShield Healthcare Plan of GeorgiaAnthem® BlueCross and BlueShield

Your Contract Code: 548569

Your Plan: 68593

Your Network: \*PPO

This summary of benefits is a This is a testbrief outline of coverage, designed to help you with the selection process. This policy has exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance agent or contact us. If there is a difference between this summary and the contract of coverage, **the contract of coverage will prevail**.

This benefit summary is not to be distributed without also providing access to the applicable Anthem HealthKeepersBCBS and its affiliate HealthKeepers, Inc. enrollment brochure.

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 Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/IPA, and services for mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

|  |  |
| --- | --- |
| Employer’s Annual Health Reimbursement Account Contributions: |  |
| This is a health reimbursement account (HRA)-based medical plan with a health reimbursement account. You can use this account to help you pay for eligible medical and pharmacy. You can earn additional credits by doing good things for your health. See programs in the Healthy Support and Rewards section. | |
| Annual Health Incentive Account Plus Contribution: |  |
| This is a health incentive account (HIA Plus) based medical plan with a health incentive account. You can use this account to help you pay for eligible medical and pharmacy. You can earn additional credits by doing good things for your health. See programs in the Healthy Support and Rewards section. | |

| Covered Medical Benefits | | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider | |
| Covered Medical Benefits | Cost if you use a Level 1 Network ProviderCost if you use a Tier 1 Network ProviderCost if you use a Preferred Network ProviderCost if you use a Value Tier 1 In-Network (INET) Provider | Cost if you use a Level 2 Network ProviderCost if you use a Tier 2 Network ProviderCost if you use an In-Network ProviderCost if you use a Participating Tier 2 In-Network (INET) Provider | Cost if you use a Out-of-Network (OON) Provider Cost if you use a Out-of-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.  Note: A portion of the medical deductible in the amount of /person must be satisfied before HRAHIA can be used.  The deductible for Value Tier 1 In-Network (INET) and Participating Tier 2 In-Network (INET) is combined. Satisfying one helps satisfy the other.  The deductible for Preferred Network and In-Network is combined. Satisfying on helps satisfy the other. | person / family | person / family | person / familyNot covered | |
| 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.  Note: A portion of the medical deductible in the amount of /person must be satisfied before HRAHIA can be used.  The deductible for In-Network and Non-Network is combined. Satisfying on helps satisfy the other. | | person / family | person / familyNot covered | |
| 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 your benefit period. See notes section for additional information regarding your out of pocket maximum.  The Out-of-Pocket limit for In-Network and Non-Network is combined. Satisfying one helps satisfy the other. | | person / family | person / family  Not covered | |
| 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 your benefit period. See notes section for additional information regarding your out of pocket maximum.  The Out-of-Pocket limit for Value Tier 1 In-Network (INET) and Participating Tier 2 In-Network (INET) is combined. Satisfying one helps satisfy the other. | person / family | person / family | person / family  Not covered | |
| 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. Immunizations for children prior to their 6th birthday have No Cost Share for In-Network and Non-Network Charges. This applies to childhood immunizations only, not other preventive care. Contraceptive methods approved by FDA and prescribed for a woman by her health care provider, subject to reasonable medical management, will be covered without cost sharing requirements. | |  |  | |
| 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. Contraceptive methods approved by FDA and prescribed for a woman by her health care provider, subject to reasonable medical management, will be covered without cost sharing requirements. |  |  |  | |
| Doctor Home and Office Services | |  |  | |
| Primary Care Office Visit to treat an injury or illness  Primary Care Visit to treat an injury or illness  Hospital clinics are not covered.  All services performed in the office are included in the office copay.  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.  When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Surgery Performed by a Primary Care Physician/Specialist  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Enhanced Personal Healthcare Provider Office Visit  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .All office visit copayments count towards the same visit limit. | |  |  | |
| Doctor Home and Office Services |  |  |  | |
| Primary Care Office Visit to treat an injury or illness  Primary Care Visit to treat an injury or illness  Hospital Clinics are not covered.  All services performed in the office are included in the office copay.  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.  When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.  Coverage for Preferred NetworkLevel 1 Network Tier 1 Network Provider, In-Network Level 2 Network [Tier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred Network Level 1 Network Tier 1 Network and In-Network Level 2 Network Tier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Surgery Performed by a Primary Care Physician/Specialist  Coverage for Preferred Network Level 1 Network Tier 1 Network Provider, In-Network Level 2 Network Tier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred Network Level 1 Network Tier 1 Network and In-Network Level 2 Network Tier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Enhanced Personal Healthcare Provider Office Visit  Coverage for Preferred Network Level 1 Network Tier 1 Network Provider, In-Network Level 2 Network Tier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred Network Level 1 Network Tier 1 Network and In-Network Level 2 Network Tier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Specialist Care Visit  Specialist Care Office Visit  All services performed in the office are included in the office copay.  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.  When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Specialist Care Visit  Specialist Care Office Visit  All services performed in the office are included in the office copay.  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.  When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.  Coverage for Preferred Network Level 1 Network Tier 1 Network Provider, In-Network Level 2 Network Tier 2 Network Provider and Non-Network Provider combined is limited to per  Coverage for Preferred Network Level 1 Network Tier 1 Network and In-Network Level 2 Network Tier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Prenatal and Post-natal Care  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  In-Network preventative prenatal services are covered at 100%. | |  |  | |
| Routine Prenatal Care  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  In-Network preventative prenatal services are covered at 100%.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  In-Network preventative prenatal services are covered at 100%. | |  |  | |
| Routine Postnatal Care  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Prenatal Preventive Care  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  In-Network preventative prenatal services are covered at 100%. | |  |  | |
| Post-natal Office Visit  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Prenatal and Post-natal Care  In-Network preventative prenatal services are covered at 100%  Coverage for Preferred Network Level 1 Network Tier 1 Network Provider, In-Network Level 2 Network Tier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred Network Level 1 Network Tier 1 Network and In-Network Level 2 Network Tier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Routine Prenatal Care  Coverage for Preferred Network Level 1 Network Tier 1 Network Provider, In-Network Level 2 Network Tier 2 Network Providerand Non-Network Provider combined is limited to per .  Coverage for Preferred Network Level 1 Network Tier 1 Network and In-Network Level 2 Network Tier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  In-Network preventative prenatal services are covered at 100%.  Coverage for Preferred Network Level 1 Network Tier 1 Network Provider, In-Network Level 2 Network Tier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred Network Level 1 Network Tier 1 Network and In-Network Level 2 Network Tier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  In-Network preventative prenatal services are covered at 100%. |  |  |  | |
| Routine Postnatal Care  Coverage for Preferred Network Level 1 Network Tier 1 Network Provider, In-Network Level 2 Network Tier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred Network Level 1 Network Tier 1 Network and In-Network Level 2 Network Tier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Coverage for Preferred Network Level 1 Network Tier 1 Network Provider, In-Network Level 2 Network Tier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred Network Level 1 Network Tier 1 Network and In-Network Level 2 Network Tier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Prenatal Preventive Care  In-Network preventative prenatal services are covered at 100%.  Coverage for Preferred Network Level 1 Network Tier 1 Network Provider, In-Network Level 2 Network Tier 2 Network Providerand Non-Network Provider combined is limited to per .  Coverage for Preferred Network Level 1 Network Tier 1 Network and In-Network Level 2 Network Tier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Coverage for Preferred Network Level 1 Network Tier 1 Network Provider, In-Network Level 2 Network Tier 2 Network Providerand Non-Network Provider combined is limited to per .  Coverage for Preferred Network Level 1 Network Tier 1 Network and In-Network Level 2 Network Tier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Post-natal Office Visit  Coverage for Preferred Network Level 1 Network Tier 1 Network Provider, In-Network Level 2 Network Tier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred Network Level 1 Network Tier 1 Network and In-Network Level 2 Network Tier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Other Practitioner Visits: | |  |  | |
| Retail Health Clinic  Retail Health Clinic Visit  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| On-line Visit  On-line Medical Visit  On-line Medical Visit  Live Health Online is the preferred telehealth solutions ([[www.livehealthonline.com](file:///C:\Users\ac50533\AppData\Local\Temp\109\www.livehealthonline.com)](file:///C:\Users\ac50533\AppData\Local\Temp\109\www.livehealthonline.com))  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  |
| Spinal Manipulation  Manipulation Therapy  Manipulation Therapy  Chiropractic Services  Chiropractic Services  Chiropractic/Manipulation Therapy  Chiropractic  Coverage for In-Network and Non-Network Provider combined is limited to for Rehabilitation and Habilitative for Physical/Manipulation therapy excluding Chiropractic Services per . | |  |  |
| Acupuncture  Coverage is limited to Pain Management.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Other Practitioner Visits: |  |  |  | |
| Retail Health Clinic  Retail Health Clinic Visit  Coverage for Preferred Network Level 1 Network Tier 1 Network Provider, In-Network Level 2 Network Tier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred Network Level 1 Network Tier 1 Network and In-Network Level 2 Network Tier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| On-line Visit  On-line Medical Visit  On-line Medical Visit  Live Health Online is the preferred telehealth solutions ([[www.livehealthonline.com](file:///C:\Users\ac50533\AppData\Local\Temp\109\www.livehealthonline.com)](file:///C:\Users\ac50533\AppData\Local\Temp\109\www.livehealthonline.com))  Coverage for Preferred Network Level 1 Network Tier 1 Network Provider, In-Network Level 2 Network Tier 2 Network Providerand Non-Network Provider combined is limited to per .  Coverage for Preferred Network Level 1 Network Tier 1 Network and In-Network Level 2 Network Tier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Spinal Manipulation  Manipulation Therapy  Manipulation Therapy  Chiropractic Services  Chiropractic Services  Chiropractic/Manipulation Therapy  Chiropractic  Coverage for Preferred Network,Level 1 Network,Tier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to for Rehabilitation and Habilitative for Physical/Manipulation therapy excluding Chiropractic Services per .  Coverage for Preferred Network Level 1 Network Tier 1 NetworkProvider and In-Network Level 2 Network Tier 2 Network Provider combined is limited to f or Rehabilitation and Habilitative for Physical/Manipulation therapy excluding Chiropractic Services per . |  |  |  | |
| Acupuncture  Coverage is limited to Pain Management.  Coverage for Preferred Network Level 1 Network Tier 1 Network Provider, In-Network Level 2 Network Tier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred Network Level 1 Network Tier 1 Network and In-Network Level 2 Network Tier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Other Services in an Office: | |  |  | |
| Allergy Testing  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Allergy Testing  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Allergy Testing Performed by a Primary Care Physician  Allergy Testing Performed by a Specialist  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Chemo/Radiation Therapy  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Chemo/Radiation Therapy Performed by a Primary Care Physician  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Chemo/Radiation Therapy Performed by a Specialist  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Chemo/Radiation Therapy Performed by a Primary Care Physician  Chemo/Radiation Therapy Performed by a Specialist  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Radiation/Chemotherapy/Non Preventive Infusion & Injection  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Hemodialysis  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Dialysis/Hemodyalisis  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Hemodialysis Performed by a Primary Care Physician  Hemodialysis Performed by a Specialist  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Prescription Drugs  For the drugs itself dispensed in the office through infusion/injection.  Drugs Administered in the Office  For the drugs itself dispensed in the office through infusion/injection.  Prescription Drugs Administered in an Office by a Primary Care Physician  For the drugs itself dispensed in the office through infusion/injection.  Prescription Drugs Administered in an Office by a Specialist  For the drugs itself dispensed in the office through infusion/injection. | |  |  | |
| Other Services in an Office: |  |  |  | |
| Allergy Testing  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Allergy Testing  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Allergy Testing Performed by a Primary Care Physician  Allergy Testing Performed by a Specialist  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Chemo/Radiation Therapy  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per ..  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Chemo/Radiation Therapy Performed by a Specialist  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Chemo/Radiation Therapy Performed by a Primary Care Physician  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Chemo/Radiation Therapy Performed by a Primary Care Physician  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Chemo/Radiation Therapy Performed by a Specialist  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-Network Level 2 Network Tier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Radiation/Chemotherapy/Non Preventive Infusion & Injection  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Hemodialysis  Dialysis/Hemodyalisis  Hemodialysis Performed by a Specialist  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to ntatalper .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Prescription Drugs.  For the drugs itself dispensed in the office through infusion/injection.  Drugs Administered in the Office  For the drugs itself dispensed in the office through infusion/injection.  Prescription Drugs Administered in an Office by a Primary Care Physician  For the drugs itself dispensed in the office through infusion/injection.  Prescription Drugs Administered in an Office by a Specialist  For the drugs itself dispensed in the office through infusion/injection. |  |  |  | |
| Diagnostic Services  Lab: | |  |  | |
| Office  Office Cost Share applies only when Freestanding/Reference Labs are not used.  All services performed in the office are included in the office copay.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Office Performed by a Primary Care Physician  Office Cost Share applies only when Freestanding/Reference Labs are not used  All services performed in the office are included in the office copay.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Office Performed by a Specialist  Coverage for In-Network Provider and Non-Network Provider combined is limited to per  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Freestanding Lab/Reference Lab  Freestanding Laboratory Facility  Preferred Reference Lab  Empire’s participating Freestanding Labs are Laboratory Corporation of America or Quest Diagnostics. Please check Provider Finder for additional participating Freestanding Labs in your area.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Outpatient Hospital  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Diagnostic Services  Lab: |  |  |  | |
| Office  Office Cost Share applies only when Freestanding/Reference Labs are not used.  All services performed in the office are included in the office copay.  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per . |  |  |  | |
| Office Performed by a Primary Care Physician  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-Network Level 2 Network Tier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per . |  |  |  | |
| Office Performed by a Specialist  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per . |  |  |  | |
| Freestanding Lab/Reference Lab  Freestanding Laboratory Facility  Preferred Reference Lab  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Outpatient Hospital  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| X-Ray: | |  |  | |
| Office  All services performed in the office are included in the office copay.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Office Performed by a Primary Care Physician  Office Performed by a Specialist  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Freestanding Radiology Center  No member cost share required for diagnostic mammograms.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per ..  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Outpatient Hospital  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| X-Ray: |  |  |  | |
| Office  All services performed in the office are included in the office copay.  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Office Performed by a Primary Care Physician  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Office Performed by a Specialist  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Freestanding Radiology Center  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Outpatient Hospital  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred Network Level 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans): | |  |  | |
| Office  All services performed in the office are included in the office copay.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Freestanding Radiology Center  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Outpatient Hospital  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | | Preferred    In-Network |  | |
| Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans): |  |  |  | |
| Office  All services performed in the office are included in the office copay.  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Freestanding Radiology Center  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Outpatient Hospital  Coverage for Preferred Network Level 1 NetwokTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Emergency and Urgent Care | |  |  | |
| Urgent Care (Office Setting)  Urgent Care Center Office Visit  Urgent Care Center Office Visit  Urgent Care  Walk In Center (Office Visit Charge)  Member cost share for Allergy injections billed separately is $10 copay. If billed with an Urgent Care Facility charge, it will be covered under the UC copayment, there is no additional cost to the member for the injection.  Member cost share for Allergy injections billed separately is $5 copay. If billed with an Urgent Care Facility charge, it will be covered under the UC copayment, there is no additional cost to the member for the injection.  The Urgent Care cost share applies to both office and facility based Urgent Care providers. If your plan includes a copay for Urgent Care and additional services are provided, these services may be subject to deductible and coinsurance.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Urgent care(Facility Setting) | |  |  | |
| Urgent Care: Facility fees  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Urgent care(Facility Setting) | |  |  | |
| Urgent Care: Facility fees  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Urgent Care: Doctor and other services  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Urgent Care: Doctor and other services  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Emergency and Urgent Care |  |  |  | |
| Urgent Care (Office Setting)  Urgent Care Center Office Visit  Urgent Care Center Office Visit  Urgent Care  Walk In Center (Office Visit Charge)  Member cost share for Allergy injections billed separately is $10 copay. If billed with an Urgent Care Facility charge, it will be covered under the UC copayment, there is no additional cost to the member for the injection.  Member cost share for Allergy injections billed separately is $5 copay. If billed with an Urgent Care Facility charge, it will be covered under the UC copayment, there is no additional cost to the member for the injection.  The Urgent Care cost share applies to both office and facility based Urgent Care providers. If your plan includes a copay for Urgent Care and additional services are provided, these services may be subject to deductible and coinsurance.  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Urgent care(Facility Setting) |  |  |  | |
| Urgent Care: Facility fees  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Urgent care(Facility Setting) |  |  |  | |
| Urgent Care: Facility fees  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Urgent Care: Doctor and other services  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Urgent Care: Doctor and other services  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Emergency Room Facility Services  Copay waived if admitted.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Emergency Room Doctor and Other Services  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Emergency Room Facility Services  Copay waived if admitted.  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Emergency Room Doctor and Other Services  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per ..  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Ambulance (Air and Ground)  Non-emergency, Non-Network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Ambulance (Air, Ground, and Water)  Non-emergency, Non-Network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Ambulance (Air, Ground, and Water)  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Ambulance Transportation  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Ambulance Transportation  Non-emergency, Non-Network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per  All office visit copayments count towards the same visit limit. | |  |  | |
| Ambulance (Air and Ground)  Non-emergency, Non-Network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .. Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per . Coverage for Non-Network Provider is limited to per . All office visit copayments count towards the same visit limit.  Ambulance (Air, Ground, and Water)  Non-emergency, Non-Network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per . Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per . Coverage for Non-Network Provider is limited to per . All office visit copayments count towards the same visit limit.  Ambulance (Air, Ground, and Water)  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per . Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per . Coverage for Non-Network Provider is limited to per . All office visit copayments count towards the same visit limit.  Ambulance Transportation  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per . Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per . Coverage for Non-Network Provider is limited to per . All office visit copayments count towards the same visit limit.  Ambulance Transportation  Non-emergency, Non-Network air ambulance services are limited to Anthem maximum payment of $50,000 per trip.  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per . Coverage for Non-Network Provider is limited to per . All office visit copayments count towards the same visit limit. |  |  |  | |
| Outpatient Mental/Behavioral Health and Substance Abuse  Outpatient Mental Health and Substance Use Disorder  Outpatient Mental Health and Substance Use Disorder  Outpatient Mental Health and Substance Abuse | |  |  | |
| Doctor Office Visit  Doctor Office Visit and Online Visit  Doctor Office Visit and Online Visit  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Facility visit: | |  |  | |
| Facility Fees  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | | Preferred    In-Network |  | |
| Doctor Services  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Outpatient Mental/Behavioral Health and Substance Abuse  Outpatient Mental Health and Substance Use Disorder  Outpatient Mental Health and Substance Use Disorder  Outpatient Mental Health and Substance Abuse |  |  |  | |
| Doctor Office Visit  Doctor Office Visit and Online Visit  Doctor Office Visit and Online Visit  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Facility visit: |  |  |  | |
| Facility Fees  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Doctor Services  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Outpatient Surgery | |  |  | |
| Facility Fees: | |  |  | |
| Hospital  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | | Preferred    In-Network |  | |
| Freestanding Surgical Center  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Doctor and Other Services: | |  |  | |
| Surgery Performed by a Primary Care Physician  Surgery Performed by a Specialist  Hospital  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Freestanding Surgical Center  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Outpatient Surgery |  |  |  | |
| Facility Fees: |  |  |  | |
| Hospital  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Freestanding Surgical Center  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Doctor and Other Services: |  |  |  | |
| Surgery Performed by a Primary Care Physician  Surgery Performed by a Specialist  Hospital  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Freestanding Surgical Center  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 NetworkProvider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)  Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder):  Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder):  Hospital Stay (all Inpatient stays including Maternity, Mental/Behavioral Health, Substance Abuse, Infertility, Hospice and Human Organ and Tissue Transplant services):  Hospital Stay (all Inpatient stays including Maternity): | |  |  | |
| Facility fees (for example, room & board)  Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs In-Network Provider is limited to per . | | Preferred    In-Network |  | |
| Human Organ and Tissue Transplants  Acquisition and transplant procedures, harvest and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | | Preferred    In-Network |  | |
| Doctor and other services  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)  Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder):  Hospital Stay (all Inpatient stays including Maternity, Mental and Substance Use Disorder):  Hospital Stay (all Inpatient stays including Maternity, Mental/Behavioral Health, Substance Abuse, Infertility, Hospice and Human Organ and Tissue Transplant services):  Hospital Stay (all Inpatient stays including Maternity): |  |  |  | |
| Facility fees (for example, room & board)  Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs Preferred Network,Level 1 Network,Tier 1 Network, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs Preferred NetworkLevel 1 NetworkTier 1 Network Provider and In-NetworkLevel 2 NetworkTier 2 Network Provider [combined is limited to per . |  |  |  | |
| Human Organ and Tissue Transplants  Acquisition and transplant procedures, harvest and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Doctor and other services  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Recovery & Rehabilitation | |  |  | |
| Home Health Care  Home Care Visits  Visit limit does not apply to Home Infusion Therapy or Home Dialysis.  Coverage is limited to per . | |  |  | |
| Recovery & Rehabilitation |  |  |  | |
| Home Health Care  Home Care Visits  Visit limit does not apply to Home Infusion Therapy or Home Dialysis.  Coverage is limited to per . |  |  |  | |
| Rehabilitation services (for example, physical/speech/occupational therapy): | |  |  | |
| Office Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to per . Coverage for rehabilitative and habilitative physical therapy is limited to per . Coverage for rehabilitative and habilitative occupational therapy is limited to per . Coverage for rehabilitative and habilitative speech therapy is limited to per . Applies to In-Network and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits. | |  |  | |
| Outpatient Hospital Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to per . Coverage for rehabilitative and habilitative physical therapy is limited to per . Coverage for rehabilitative and habilitative occupational therapy is limited to per . Coverage for rehabilitative and habilitative speech therapy is limited to per . Applies to In-Network and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits. | |  |  | |
| Rehabilitation services (for example, physical/speech/occupational therapy): |  |  |  | |
| Office  Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to per . Coverage for rehabilitative and habilitative occupational therapy is limited to per . Coverage for rehabilitative and habilitative speech therapy is limited to per . Applies to Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits. |  |  |  | |
| Outpatient Hospital  Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to per . Coverage for rehabilitative and habilitative physical therapy is limited to per . Coverage for rehabilitative and habilitative occupational therapy is limited to per . Coverage for rehabilitative and habilitative speech therapy is limited to per . Applies to Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits. |  |  |  | |
| Habilitation services (for example, physical/speech/occupational therapy): | |  |  | |
| Office Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to per . Coverage for rehabilitative and habilitative physical therapy is limited to per . Coverage for rehabilitative and habilitative occupational therapy is limited to per . Coverage for rehabilitative and habilitative speech therapy is limited to per . Applies In-Network and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits. | |  |  | |
| Outpatient Hospital Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to per . Coverage for rehabilitative and habilitative physical therapy is limited to per . Coverage for rehabilitative and habilitative occupational therapy is limited to per . Coverage for rehabilitative and habilitative speech therapy is limited to per . Applies to In-Network Provider and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits. | |  |  | |
| Habilitation services (for example, physical/speech/occupational therapy): |  |  |  | |
| Office  Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to per . Coverage for rehabilitative and habilitative physical therapy is limited to per . Coverage for rehabilitative and habilitative occupational therapy is limited to per . Coverage for rehabilitative and habilitative speech therapy is limited to per . Applies to Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits. |  |  |  | |
| Outpatient Hospital  Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to per . Coverage for rehabilitative and habilitative physical therapy is limited to per . Coverage for rehabilitative and habilitative occupational therapy is limited to per . Coverage for rehabilitative and habilitative speech therapy is limited to per . Applies to Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network and Non-Network Provider combined. Visit limit does not apply when performed as part of Hospice, Home Health, Early Intervention or Autism services. Visit limits are combined both across outpatient and other professional visits. |  |  |  | |
| Cardiac rehabilitation | |  |  | |
| Office  Office Visit  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Outpatient Hospital  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Cardiac rehabilitation |  |  |  | |
| Office  Office Visit  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Outpatient Hospital  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Pulmonary rehabilitation | |  |  | |
| Office  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Outpatient Hospital  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Pulmonary rehabilitation |  |  |  | |
| Office  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Outpatient Hospital  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Skilled Nursing Care (in a facility)  Coverage for Inpatient rehabilitation and skilled nursing services combined In- Network Providers and Non-Network Providers combined is limited to per .  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  All office visit copayments count towards the same visit limit. | | Preferred    In-Network |  | |
| Skilled Nursing Care (in a facility)  Coverage for Inpatient rehabilitation and skilled nursing services combined In- Network Providers and Non-Network Providers combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider, In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Hospice  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Coverage for In-Network Provider and Non-Network Provider combined is limited to per .  Coverage for In-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. | |  |  | |
| Hospice  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit.  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network Provider. In-NetworkLevel 2 NetworkTier 2 Network Provider and Non-Network Provider combined is limited to per .  Coverage for Preferred NetworkLevel 1 NetworkTier 1 Network and In-NetworkLevel 2 NetworkTier 2 Network Provider combined is limited to per .  Coverage for Non-Network Provider is limited to per .  All office visit copayments count towards the same visit limit. |  |  |  | |
| Durable Medical Equipment  Coverage for hearing aids services left ear is limited to 1 unit every 2 years and right ear is limited to 1 unit every 2 years. Apply to Tier 1 name’, ‘Tier 2 Name’ and Out-of-Network (OON) Providers.  Coverage for hearing aids services is limited to 1 unit every 5 years. | |  |  | |
| Durable Medical Equipment  Coverage for hearing aids services left ear is limited to 1 unit every 2 years and right ear is limited to 1 unit every 2 years. Apply to Tier 1 name’, ‘Tier 2 Name’ and Out-of-Network (OON) Providers.  Coverage for hearing aids services is limited to 1 unit every 5 years. |  |  |  | |
| Prosthetic Devices  Coverage for wigs needed after cancer treatment In-Network and Non-Network Provider combined is limited to per .  Coverage for wigs needed after cancer treatment In-Network is limited to per . | |  |  | |
| Prosthetic Devices  Coverage for wigs needed after cancer treatment Preferred Network,Level 1 Network,Tier 1 Network, In-NetworkLevel 2 NetworkTier 2 Network and Non-Network Provider combined is limited to per .  Coverage for wigs needed after cancer treatment Preferred Network,Level 1 Network,Tier 1 Network, In-NetworkLevel 2 NetworkTier 2 Network combined is limited to per . |  |  |  | |

| Covered Prescription Drug Benefits | | | | Cost if you use an In-Network Provider | | | Cost if you use a Non-Network Provider |
| Covered Prescription Drug Benefits | Cost if you use a Level 1 Network ProviderCost if you use a Tier 1 Network ProviderCost if you use a Preferred Network ProviderCost if you use a Value Tier 1 In-Network (INET) Provider | Cost if you use a Level 2 Network ProviderCost if you use a Tier 2 Network ProviderCost if you use an In-Network ProviderCost if you use a Participating Tier 2 In-Network (INET) Provider | | | Cost if you use a Out-of-Network (OON) Provider Cost if you use a Out-of-Network Provider Cost if you use a Non-Network Provider | | |
| Pharmacy Deductible | | | | person / family  Combined with medical deductible  Person  Not applicable | | | Not covered  Combined with medical deductible  person / family  Person  Not applicable |
| Pharmacy Deductible | Combined with In-Network medical deductible  person / family  person  Not applicable | Combined with medical deductible  person / family  person  Not applicable | | | Not coveredCombined with medical deductible person / family personNot applicable | | | |
| Pharmacy Out of Pocket | | | | person / family  Combined with medical out of pocket maximum  Not applicable | | | Not applicable  Not covered  Combined with medical out of pocket maximum  person / family |
| Pharmacy Out of Pocket | Combined with In-Network medical out of pocket maximum  person / family  Not Applicable | Combined with medical out of pocket maximum  person / family  Not Applicable | | | Not applicable  Not covered  Combined with medical out of pocket maximum  person / family | | | |
| Prescription Drug Coverage  Select Drug List  National Drug List  Essential Drug List  Traditional Open Drug List  Traditional Open Drug List  This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.  This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies. | | | |  | | |  |
| Prescription Drug Coverage Select Drug List  National Drug List  Essential Drug List  Traditional Open Drug List  Traditional Open Drug List  This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.  This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies. |  |  | | |  | | | |
| Preventive Drugs  Preventive Rx Plus: Deductible is waived for certain drugs for diabetes, asthma, heart health, high blood pressure, high cholesterol, stroke, and osteoporosis. | | | |  | | |  |
| Tier 1 - Typically Generic | | | | $ per Prescription after Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription / % Coinsurance  % Coinsurance after Pharmacy Deductible is met | | | (retail only). (retail and home delivery).  Not covered |
| Tier 1a - Typically Lower Cost Generic | | | | $ per Prescription after Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription / % Coinsurance  % Coinsurance | | | (Retail Only). (Retail and Home Delivery).  Not covered |
| Tier 1b – Typically Generic | | | | $ per Prescription after Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription / % Coinsurance  % Coinsurance after Deductible is met | | | (Retail Only). (Retail and Home Delivery).  Not Covered |
| Tier 2 - Typically Preferred Brand | | | | $ per Prescription after Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription / % Coinsurance  % Coinsurance after Deductible is met | | | (Retail Only). (Retail and Home Delivery).  Not covered |
| Preventive Drugs  Preventive Rx Plus: Deductible is waived for certain drugs for diabetes, asthma, heart health, high blood pressure, high cholesterol, stroke, and osteoporosis. |  | |  | | |  | | | |
| Tier 1 - Typically Generic | $ per Prescription after Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription / % Coinsurance  % Coinsurance after Pharmacy Deductible is met | | $ per Prescription after Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription / % Coinsurance  % Coinsurance after Pharmacy Deductible is met | | | (Retail Only). (Retail and Home Delivery).  Not covered | | | |
| Tier 1a - Typically Lower Cost Generic | $ per Prescription after Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription / % Coinsurance  % Coinsurance | | $ per Prescription after Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription / % Coinsurance  % Coinsurance | | | (Retail Only). (Retail and Home Delivery).  Not covered | | | |
| Tier 1b – Typically Generic | $ per Prescription after Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription / % Coinsurance  % Coinsurance after Deductible is met | | $ per Prescription after Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription / % Coinsurance  % Coinsurance after Deductible is met | | | (Retail Only). (Retail and Home Delivery).  Not covered | | | |
| Tier 2 - Typically Preferred Brand | $ per Prescription after Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription / % Coinsurance  % Coinsurance after Deductible is met | | $ per Prescription after Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription after Pharmacy Deductible is met / % Coinsurance after Pharmacy Deductible is met  $ per Prescription / % Coinsurance  % Coinsurance after Deductible is met | | | (Retail Only). (Retail and Home Delivery).  Not covered | | | |
| Tier 1 - Typically Generic  Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. | | | | (retail and home delivery).  (retail and home delivery).  (retail only).  (home delivery only). | | | (retail only). (retail and home delivery).  Not Covered |
| Tier 1 - Typically Generic  Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. | (retail and home delivery).  (retail and home delivery).  (retail only).  (home delivery only). | | (retail only). | | | (retail only). (retail and home delivery).  Not Covered | | | |
| Tier 1a - Typically Lower Cost Generic  Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. | | | | (retail and home delivery).  (retail and home delivery).  (retail only).  (home delivery only). | | | (retail only). (retail and home delivery).  Not Covered |
| Tier 1b - Typically Generic  Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. | | | | (retail and home delivery).  (retail and home delivery).  (retail only).  (home delivery only). | | | (retail only). (retail and home delivery).  Not Covered |
| Tier 1a - Typically Lower Cost Generic  Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs. If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. | (retail and home delivery).  (retail and home delivery).  (retail only).  (home delivery only). | | (retail only). | | | (retail only). (retail and home delivery).  Not Covered | | | |
| Tier 1b - Typically Generic  Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. | (retail and home delivery).  (retail and home delivery).  (retail only).  (home delivery only). | | (retail only). | | | (retail only). (retail and home delivery).  Not Covered | | | |
| Tier 2 – Typically Preferred Brand  Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. | | | | (retail and home delivery).  (retail and home delivery).  (retail only).  (home delivery only). | | | (retail only). (retail and home delivery).  Not Covered |
| Tier 2 – Typically Preferred Brand  Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. | (retail and home delivery).  (retail and home delivery).  (retail only).  (home delivery only). | | (retail only). | | | (retail only). (retail and home delivery).  Not Covered | | | |
| Tier 3 - Typically Non-Preferred Brand  Tier 3 - Typically Non-Preferred Brand/Specialty Drugs  Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. | | | | (retail and home delivery).  (retail and home delivery).  (retail only).  (home delivery only). | | | (retail only). (retail and home delivery).  Not Covered |
| Tier 3 - Typically Non-Preferred Brand  Tier 3 - Typically Non-Preferred Brand/Specialty Drugs  Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program).Covers up to 90 day supply (retail maintenance pharmacy). No coverage for non-formulary drugs.If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. | (retail and home delivery).  (retail and home delivery).  (retail only).  (home delivery only). | | (retail only). | | | (retail only). (retail and home delivery).  Not Covered | | | |
| Tier 4 - Typically Specialty (brand and generic)  Tier 4 - Typically Preferred Specialty (brand and generic)  Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. | | | | (retail and home delivery).  (retail and home delivery).  (retail only).  (home delivery only). | | | (retail only). (retail and home delivery).  Not Covered |
| Tier 4 - Typically Specialty (brand and generic)  Tier 4 - Typically Preferred Specialty (brand and generic)  Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. | (retail and home Delivery).  (retail and home Delivery).  (retail only).  (home delivery only). | | (retail only). | | | (retail only). (Rretail and home delivery).  Not Covered | | | |
| Tier 5a – Typically Specialty (Non-Preferred)  Tier 5 - Typically Non-Preferred Specialty (brand and generic)  Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. | | | | (retail and home delivery).  (retail and home delivery).  (retail only).  (home delivery only). | | | (retail only). (retail and home delivery).  Not Covered |
| Tier 5a – Typically Specialty (Non-Preferred)  Tier 5 - Typically Non-Preferred Specialty (brand and generic)  Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply. Coverage is also provided for up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives, when dispensed or furnished at one time. | (retail and home delivery).  (retail and home delivery).  (retail only).  (home delivery Only). | | (retail only). | | | (retail only). (retail and home delivery).  Not Covered | | | |

| Covered Vision Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
| --- | --- | --- |
| This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member’s choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.  Only children's vision services count towards your out of pocket limit.  Adult and children's vision services count towards your out of pocket limit. |  |  |
| Children's Vision Essential Health Benefits (up to age ) |  |  |
| Child Vision Deductible | $0 person  Combined with medical deductible | Not ApplicableCombined with medical deductible$0 person |
| Vision exam  Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period. |  |  |
| Frames  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods. |  |  |
| Lenses  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods. |  |  |
| Elective contact lenses  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods. |  |  |
| Non-Elective Contact Lenses  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods. |  |  |
| Adult Vision (age and older) |  |  |
| Adult Vision Deductible | $0 person  Combined with medical deductible | Combined with medical deductibleNot Applicable$0 person |
| Vision exam  Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period. |  |  |
| Frames  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods. |  |  |
| Lenses  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods. |  |  |
| Elective contact lenses  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods. |  |  |
| Non-Elective Contact Lenses  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.  Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit every 2 benefit periods. |  |  |

| Covered Vision Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
| --- | --- | --- |
| This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail. |  |  |
| Child Vision exam  Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period. |  |  |
| Adult Vision exam  Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period. |  |  |

| Covered Dental Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
| --- | --- | --- |
| This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/Disclosure form/Certificate. If there is a difference between this summary and either Evidence of Coverage/Disclosure form/Certificate, the Evidence of Coverage/Disclosure form/Certificate will prevail.  Only children's dental services count towards your out of pocket limit. |  |  |
| Children's Dental Essential Health Benefits  Diagnostic and preventive  Coverage for In-Network Providers and Non-Network Providers is limited to 2 visits per 12 months. |  |  |
| Basic services |  |  |
| Major services |  |  |
| Medically Necessary Orthodontia services |  |  |
| Cosmetic Orthodontia services |  |  |
| Deductible | Combined with medical deductible    Not Applicable | Not covered Combined with medical deductible  Not Applicable |
| Adult Dental |  |  |
| Diagnostic and preventive  Coverage for In-Network Providers and Non-Network Providers is limited to 2 visits per 12 months. |  |  |
| Basic services |  |  |
| Major services |  |  |
| Deductible | Combined with medical deductible  Not Applicable | Not coveredCombined with medical deductible |
| Annual maximum |  | Not covered |

|  |
| --- |
| Your plan also includes the following Healthy Support & Rewards features.  To see your rewards and additional information log into the Anthem website at empireblue.com or call the customer service number on your member ID card. |

|  |  |  |
| --- | --- | --- |
|  |  |  |

Notes:

All medical services subject to a coinsurance are also subject to the annual medical deductible, if deductible is applicable to plan.

The prescription drug plan listed on this Summary meets the Centers for Medicare and Medicaid Services (CMS) standard for Creditable Coverage under the Medicare Modernization Act of 2003.

Our Preauthorization is required before You receive certain Covered Services.  You are responsible for requesting Preauthorization for the following services: All inpatient admissions, including maternity admissions and admissions for illness or injury to newborns; Inpatient Mental Health Care, Substance Abuse Care and Alcohol Detoxification; Skilled Nursing Facility; Outpatient/Ambulatory Surgical Treatments (certain procedures); Chiropractic Care (after the 5th visit); Physical, Occupational, and Speech Therapy; Diagnostics; Outpatient Treatments; Air Ambulance; High tech radiology services: MRI, MRA, PET, CAT, Nuclear Technology services; Durable Medical Equipment; Prosthetics and Orthotics; Assistive Communication Devices.

If You seek coverage for services that require Preauthorization or notification, You or Your Provider must call Us or Our vendor at the number indicated on Your ID card.

Preventive care benefits not subject to copay, deductible and coinsurance; when provided In-Network include: mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.

Your plan requires a selection of a Primary Care Physician. Your plan requires a referral from your Primary Care Physician for select covered services.

To receive a 90-day supply of prescription drugs through Empire’s Mail-Order Program, the prescription must be written specifically for a 90-day supply.

The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to 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

The family deductible and out-of-pocket maximum are non-embedded meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The individual deductible and individual out-of-pocket maximum only apply to individuals enrolled under single coverage.

If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.

If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.

Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.

If your plan includes out of network benefits, all services with calendar/plan year limits are combined both in and out of network.

If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge.

Your copays, coinsurance and deductible count toward your out of pocket amount.

To view your prescription formulary list log on to [www.anthem.com/health-insurance/customer-care/forms-library](http://www.anthem.com/health-insurance/customer-care/forms-library)

In-network preventive care is not subject to deductible, if you plan has a deductible.

This plan includes Home Delivery (Mail Order). Home Delivery copays are different than the Retail Pharmacy Copays.

If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating providers charge. When receiving care from providers out of network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out of network out of pocket limit.

Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.

Dependent age: to end of the month in which the child attains age 26.

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.

Certain diabetic and asthmatic supplies are available at Network pharmacies, diabetic test strips paid same as any other drug.

Autism Spectrum Disorder Limit is combined across professional visits and outpatient facilities. Limit is combined in network and out of network, if applicable. Benefit is limited to 1,000 hours per benefit period between ages 1 and 7. Benefit is limited to 20 hours per month between ages 7 and 21. Partial hour increments (e.g. 15 minutes) will accrue towards limits.

Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.

Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.

Prescription Drug Card program includes chemotherapeutic agents and immunosuppressant at the appropriate generic copayment.

Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

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).

If office visit is a coinsurance, the coinsurance also applies to allergy injections.

Plan applies a copayment to the first PCP/SCP office visit charge/surgery and all other office visit charges are subject to deductible and coinsurance.

Certain diabetic and asthmatic supplies are covered subject to applicable prescription drug copayments/coinsurance when you get them from an In network pharmacy. These supplies are covered as medical supplies and durable medical equipment if you get them from an Out of network pharmacy. Diabetic test strips are covered subject to applicable prescription drug copayment/coinsurance. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

No Copayment or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance. Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

DME - 50% coinsurance for Network/Non-Network Durable Medical Equipment, Medical Supplies, Orthotics, Asthma Supplies, and Phenylketonuria (PKU).  Excludes Prosthetics, Wigs, Diabetic Supplies and Mastectomy prostheses which will apply the plan’s cost shares.

DME - 50% coinsurance for Durable Medical Equipment, Medical Supplies (including Diabetic Supplies), Orthotics, Asthma Supplies, and Phenylketonuria (PKU).  Excludes Prosthetics, Wigs, and Mastectomy prostheses which will apply the plan’s cost shares.

DME 50% coinsurance for Network/Non-network Durable Medical Equipment, Medical Supplies, Prosthetics, and Orthotics. Excludes Diabetic Supplies, Asthmatic Supplies, and Mastectomy Prostheses which will apply the plan’s cost shares.

DME - 50% coinsurance for network/non-network Durable Medical Equipment and Medical Supplies. Excludes Prosthetics, Orthotics, Diabetic Supplies, Asthmatic Supplies, and Mastectomy Prostheses which will apply the plan’s cost share.

Exclusion of services – some benefits are limited to dollar amounts, day limit, visit limit and actual service type as defined in the Certificate and Schedule of Benefits. Some of those services are: outpatient physical medicine therapies unless otherwise noted, Urgent Care Services, Allergy Testing and Treatment, Durable Medical Equipment, Appliances, and Orthotics.

Hospital stay for Maternity Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.

The Rx option includes the Essential formulary which is a closed drug list with a focus on therapeutic efficacy and cost effectiveness.

Network Deductibles Tier 1Level 1 and Tier 2Level 2 commingle towards each other.

PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network provider as allowed by the plan.

SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice. Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs, Geriatrics, Chiropractors or any other Network Provider as allowed by the plan.

SCP is a Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice. Specialist (SCP) copayment is applicable to all Specialists (excludes: General Physicians, Internists, Pediatricians, OB/Gyns, Geriatrics, Physical Therapy, Occupational Therapy or any other Network provider as allowed by the plan).

Diagnostic mammograms are not subject to Copayments / Coinsurance in Network office and outpatient facility settings.

Diagnostic mammograms are not subject to Copayments / Coinsurance in Network office and outpatient facility settings.

All network covered services cost share for both Tier 1Level 1 and Tier 2Level 2 apply to the Network OOP.

Annual Deductible = Upfront Network Deductible + Employer Account Contribution. Upfront Network Deductible – Members must pay a certain portion of the Deductible listed above before using their HRA account. HRA funds cannot be applied to this portion of the Deductible (known as the “upfront” Network Deductible). Amounts paid toward the upfront Network Deductible will be applied toward the annual Network Deductible. After satisfying the upfront Deductible, Members can use HRA funds to help meet the rest of the (annual) Deductible.

Bariatric Surgery is covered subject to cost share based on setting.

Immunization through age 5 – No Cost Share up to the maximum allowable amount (Network).

Benefits are limited to abortions performed to preserve the life of the female upon whom the abortion is performed. Elective abortions are not a Covered Service.

Benefits are limited to abortions due to an act of rape or incest, to avert death, or a substantial and irreversible impairment of a major bodily function.

Benefits are limited to abortions performed to preserve the life of the female upon whom the abortion is performed.

Behavioral Health Network and Non-network office visits covered at the network level. Non-Network office visits limited to 2 visits.

Urgent Care Facility Copay exclude certain diagnostic test such as MRAs, MRIs, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, Allergy Testing, and Pharmaceutical injection and drugs.

Medical Nutritional Counseling -10 visit limit per benefit period. $15 copayment per office visit excludes Preventive Nutritional Counseling.

Your Wig-1 per benefit period network/non-network covered up to $600 allowed amount during active cancer treatment and for treatment of Alopecia Totalis.

Eye Services includes 1 set of glasses or contacts per cataract surgery with a $130 per benefit period.

Private Duty Nursing – limited to $50,000 per benefit period with a lifetime maximum of $100,000.

Your Plan does not provide coverage for the following: Services that are not Medically Necessary. Experimental/Investigative Services. Complications of, or services directly related to a service or treatment that is a non Covered Service under this Certificate because it was determined by Us to be Experimental/ Investigative or non Medically Necessary. Services received from a non-covered Provider. For any condition arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. Services provided by any governmental unit, unless otherwise required by law. For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, whether declared or undeclared. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident. For court ordered testing or care unless Medically Necessary. For which you have no legal obligation to pay in the absence of this or like coverage. Charges that are not documented in Provider records. For mileage, lodging, and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service. For which benefits are payable under Medicare. Charges in excess of Our Maximum Allowable Amounts. Incurred prior to your Effective Date or after coverage ends. For any procedures, services, Prescription Drugs, equipment, or supplies provided in connection with cosmetic services. This does not apply to services required as a result of an accident, to correct a birth defect, or as part of breast reconstruction following a mastectomy. Complications directly related to cosmetic services treatment or surgery are also not covered. For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Custodial Care, convalescent care or rest cures. For dental treatment, regardless of origin or cause, except as specified in the Certificate. Weight loss programs except as specifically listed in the Certificate. For bariatric surgery, regardless of the purpose it is proposed or performed for. Complications directly related to bariatric surgery are also not covered. For marital counseling. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated in the Certificate. For hearing aids or examinations for prescribing or fitting them. This exclusion does not apply to hearing aids or examinations required for children under age 18 who are receiving the benefits described in the "Covered Services" section. For testing or treatment related to infertility. For personal hygiene, environmental control, or convenience items including but not limited to air conditioners, physical fitness equipment, or charges from a health spa or similar facility. For care received in an emergency room that is not Emergency Care, except as specified in the Certificate. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility. Nutritional or dietary supplements. For (services or supplies related to) alternative or complementary medicine, including but not limited to acupuncture, holistic medicine, hypnosis, massage therapy, and neurofeedback. Treatment of varicose veins or spider veins. Services for, and related to, many forms of immunotherapy including oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies. Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000. Prescription Drugs dispensed by any Mail Service program other than Our Mail Service, unless prohibited by law. Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order. Drugs not approved by the FDA. Drugs not requiring a Prescription by federal law (including Drugs requiring a Prescription by state law, but not by federal law), except for injectable insulin. Drugs in quantities that exceed the limits established by the Plan, or which exceed any age limits established by Us. Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes. Gene therapy including Drugs, procedures, or services related to it that introduce genetic material to replace or correct faulty or missing genetic material. Physical exams and immunizations required for travel, enrollment in insurance, employment, licensing, sports programs, or other purposes that not required by law.

For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".

This benefit overview is for illustrative purposes and some content may be pending Department of Insurance approval.

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 |

# 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

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)

|  |  |
| --- | --- |
| image12 | |
| . | image13 |

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՝ :

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 。

|  |  |
| --- | --- |
| image14 | |
|  | image15 |
| image16 | |

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le .

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 .

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 .

|  |  |  |
| --- | --- | --- |
| image17 | | |
| image18 |  | image19 |

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

|  |  |  |
| --- | --- | --- |
| image20 | | |
| image21 | image22 | . |

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: .

|  |  |  |
| --- | --- | --- |
| image23 | | |
| image24 |  | image25 |

|  |  |
| --- | --- |
| image26 | |
| image27 | |
| image28 | . |

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al .

Tagalog (Tagalog): Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang .

Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi .

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at [<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf). Complaint forms are available at [<http://www.hhs.gov/ocr/office/file/index.html>](http://www.hhs.gov/ocr/office/file/index.html).

Get help in your language 

Language Assistance Services

Curious to know what all this says? We would be too. Here’s the English version:

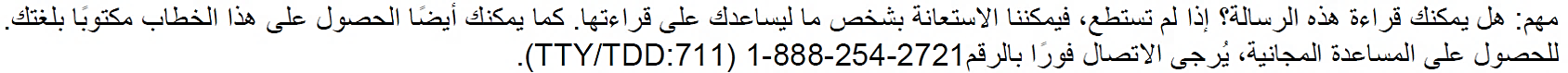
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

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.

Spanish

IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic



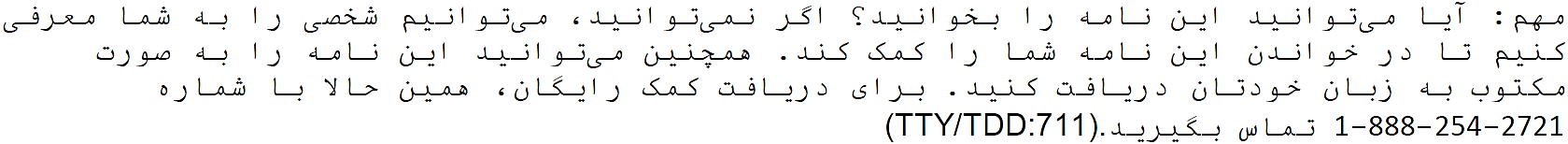
Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese

重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi



Hindi

महत्वपूण: क्य आप यह पत पढ़ सकते ह􀉇? अगर नह􀈣ं, तो हम आपको इसे पढ़ने म􀉅 मदद करने के 􀍧लए 􀍩कसी को उपलब् करा सकते ह􀉇। आप यह पत अपनी भाषा म􀉅 􀍧लखवा वा ने म􀉅 भी स􀂢म हो सकते ह􀉇। 􀇓नःशुल् मदद के 􀍧लए, कृपया पया 1-888-254-2721 पर तुरंत कॉल कर􀉅। (TTY/TDD: 711)

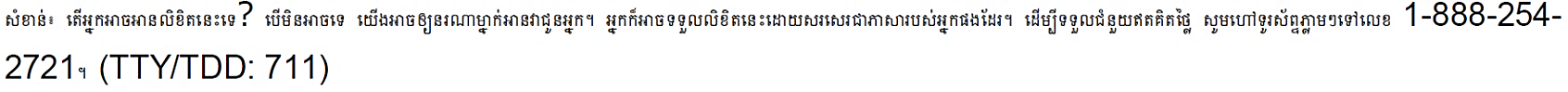
Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。 1-888-254-2721 (TTY/TDD: 711)

Khmer



Korean

중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸ􁶣 ਇਹ ਪੱਤਰ ਪੜਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹ􁶣, ਤਾਂ ਅਸ􁶣 ਇਸ ਨੂੰ ਪੜਹ੍ ਿਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸ􁶣 ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿਵੱਚ ਿਲਿਖਆ ਹੋਇਆ ਵਬੀ ਪਰ੍ਾਪ ੍ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੌਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai

หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Get help in your language 

Notice of Language Assistance

Curious to know what all this says? We would be too. Here’s the English version:

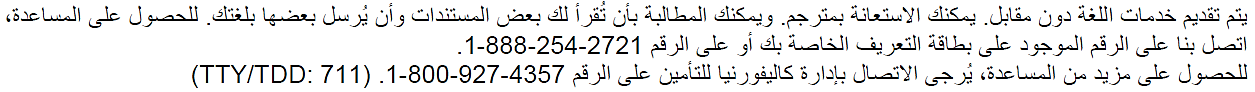
No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. (TTY/TDD: 711)

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.

Spanish

Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357. (TTY/TDD: 711)

Arabic



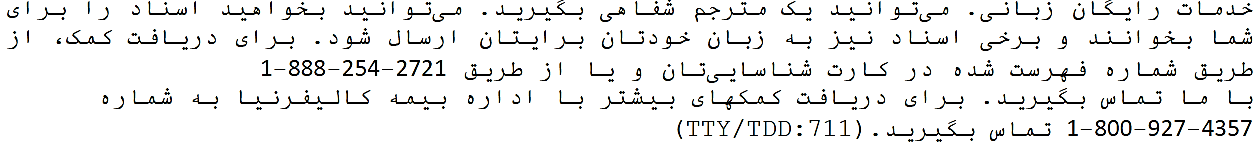
Armenian

Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հետևյալ հեռախոսահամարով՝ 1-800-927-4357: (TTY/TDD: 711)

Chinese

免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者1-888-254-2721聯絡我們。如需更多協助，請撥打1-800-927-4357 聯絡CA Dept. of Insurance。(TTY/TDD: 711)

Farsi



Hindi

􀇒बना लागत क􀈧 भाषा सेवाएँ। आप दुभा􀍪षया प्रा कर सकते ह􀉇। आप दस्ताव ्ताव ्तावे पढ़वा सकते ह􀉇 और कुछ दस्ताव ्ताव ्तावे आपको आपक􀈧 भाषा म􀉅 भेजे जा सकते ह􀉇। मदद के 􀍧लए, हम􀉅 अपने ID काडर पर सूचीबद नंबर पर या 1-888-254-2721 पर कॉल कर􀉅। अ􀍬धक मदद के 􀍧लए 1-800-927-4357 पर CA बीमा 􀍪वभाग कोकॉल कर􀉅। (TTY/TDD: 711)

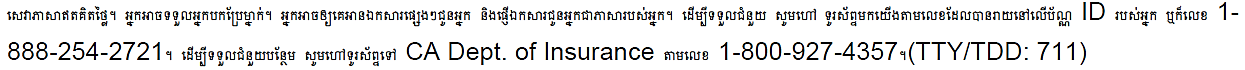
Hmong

Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntawv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntawv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357. (TTY/TDD: 711)

Japanese

無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局（1-800-927-4357）にお電話ください。(TTY/TDD: 711)

Khmer



Korean

무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오. (TTY/TDD: 711)

Punjabi

ਿਬਨਾਂ ਿਕਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸ􁶣 ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪਰ੍ਾਪ ੍ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਿਵੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉ􁷀ਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਿਜ਼ਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਿਡਪਾਰਟਮ􁶥ਟ ਔਫ ਇਨਸ਼ੋਰ􁶥ਸ ਨੂੰ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочитать документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357. (TTY/TDD: 711)

Tagalog

Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

Thai

ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการล่ามได้ ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน หากต้องการความช่วยเหลือ โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-254-2721 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357 (TTY/TDD: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357. (TTY/TDD: 711)

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.