Your summary of benefits

PT Solutions

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Open Access POS Premium Plan

Your Network: Blue Open Access POS

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$1,000 member / $3,000 family	$1,000 member / $3,000 family
Out-of-Pocket Limit	$7,150 member / $14,300 family	$3,000 member / $6,000 family
The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.		
Preventive Care / Screening / Immunization	No charge	20% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit	$35 copay per visit deductible does not apply	20% coinsurance after deductible is met
Specialist Care Visit	$50 copay per visit deductible does not apply	20% coinsurance after deductible is met
Prenatal and Post-natal Care	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic Visit	$35 copay per visit deductible does not apply	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Preferred On-line Visit *Includes Mental Health and Substance Abuse*	No charge for the first 12 visits and then $35 copay per visit deductible does not apply	20% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental Health and Substance Abuse*	$35 copay per visit deductible does not apply	20% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 20 visit(s) per year.*	$50 copay per visit deductible does not apply	20% coinsurance after deductible is met
Acupuncture	$50 copay per visit deductible does not apply	20% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	$35 copay per visit or $50 copay if performed in a specialist office deductible does not apply	20% coinsurance after deductible is met
Chemo/Radiation Therapy	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Dialysis/Hemodialysis	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Prescription Drugs - *Dispensed in the office*	0% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services **Lab:**		
Office	$35 copay per visit or $50 copay if performed in a specialist office deductible does not apply	20% coinsurance after deductible is met
Freestanding Lab/Reference Lab	0% coinsurance deductible does not apply	20% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met
X-Ray:		
Office	$35 copay per visit or $50 copay if performed in a specialist office deductible does not apply	20% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance deductible does not apply	20% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Advanced Diagnostic Imaging:		
Office	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance deductible does not apply	20% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care	$50 copay per visit deductible does not apply	20% coinsurance after deductible is met
Emergency Room Facility Services *Cost share waived if admitted.*	$500 copay per visit and 0% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance deductible does not apply	Covered as In-Network
Ambulance	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$25 copay per visit deductible does not apply	20% coinsurance after deductible is met
Facility Visit:		
Facility Fees	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Freestanding Surgical Center	$150 copay per visit and 0% coinsurance deductible does not apply	20% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Surgical Center	0% coinsurance deductible does not apply	20% coinsurance after deductible is met
Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):		
Facility Fees	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 120 visit(s) per year.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Rehabilitation services:		
Office *Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 80 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 60 visits per benefit period.*	$50 copay per visit deductible does not apply	20% coinsurance after deductible is met
Outpatient Hospital *Limits are combined with Rehabilitation office visits*.	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Cardiac rehabilitation		
Office	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 60 days combined per year.*	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Hospice	0% coinsurance deductible does not apply	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	0% coinsurance after deductible is met	20% coinsurance after deductible is met
Prosthetic Devices	0% coinsurance after deductible is met	20% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket	Combined with medical	Combined with medical
Prescription Drug Coverage *National Network with R90 and Optional home delivery Up to a 90-day supply is available at participating retail pharmacies.* *National Direct Drug List* *No coverage for non-formulary drugs.* *If a member receives a brand name drug that has a generic equivalent available, the member pays the Tier 1 copay, plus the difference in cost between the brand drug and generic drug. This does not apply when physician indicates DAW (dispense as written) or obtains an authorization.*		
Tier 1 - Typically Generic *Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery).*	$15 copay per prescription, deductible does not apply (retail) and $38 copay per prescription, deductible does not apply (home delivery)	$15 copay per prescription, deductible does not apply (retail only)
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery).*	$45 copay per prescription, deductible does not apply (retail) and $113 copay per prescription, deductible does not apply (home delivery)	$45 copay per prescription, deductible does not apply (retail only)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy). Per 90 day supply (home delivery).*	$85 copay per prescription, deductible does not apply (retail) and $213 copay per prescription, deductible does not apply (home delivery)	$85 copay per prescription, deductible does not apply (retail only)

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (retail pharmacy). Per 30 day supply (home delivery).*	20% coinsurance up to $250 per prescription, deductible does not apply (retail and home delivery)	20% coinsurance up to $250 per prescription, deductible does not apply (retail only)

Notes:

- Your copays, coinsurance and deductible count toward your out of pocket amount.
- If you have an office visit with your Primary Care Physician or Specialist at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- When using a non-network pharmacy, members are responsible for the stated copay & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Coverage. If there is a difference between this summary and the Certificate of Coverage the Certificate of Coverage will prevail.

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(TTY/TDD: 711)

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