Your summary of benefits

Anthem® BlueCross and BlueShield

Effective Date: 08.01.2020

VS Engineering

Your Plan: Anthem Blue Access PPO HSAs (with Copay) Option E4 with Rx Option C2

Your Network: Blue Access

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

This summary of benefits 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.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$5,000 person / $10,000 family	$15,000 person / $30,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$6,900 person / $13,800 family	$20,700 person / $41,400 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	30% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness *When Allergy injections are billed separately by network providers, the member is responsible for $10 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$30 copay per visit after deductible is met	30% coinsurance after deductible is met

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Specialist Care Visit *When Allergy injections are billed separately by network providers, the member is responsible for $10 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Prenatal and Post-natal Care *In-Network preventive prenatal services are covered at 100%.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$30 copay per visit after deductible is met	30% coinsurance after deductible is met
Preferred On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$10 copay per visit after deductible is met	30% coinsurance after deductible is met
Other Participating Provider On-line Visit *Includes Mental/Behavioral Health and Substance Abuse*	$30 copay per visit after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Primary Care Physician	$30 copay per visit after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy Performed by a Specialist	$50 copay per visit after deductible is met	30% coinsurance after deductible is met

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Dialysis/Hemodialysis	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Diagnostic Services		
Lab:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
X-Ray:		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met

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Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care (Office Setting) *Member cost share for Allergy injections billed separately is $10 copay after deductible. 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 injection.*	$75 copay per visit after deductible is met	30% coinsurance after deductible is met
Urgent care(Facility Setting)		
Urgent Care: Facility fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Urgent Care: Doctor and other services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$250 copay per visit and 0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Ambulance (Air, Ground, and Water) *Non-emergency non-network Ambulance Services are limited to $50,000 per occurrence.*	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$30 copay per visit after deductible is met	30% coinsurance after deductible is met
Facility visit:		
Facility Fees	0% coinsurance after deductible is met	30% coinsurance after deductible is met

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Doctor Services	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees:		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Surgical Center	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for Skilled Nursing, Inpatient Physical Medicine and Rehabilitation including day rehabilitation is limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Human Organ and Tissue Transplants *Acquisition and transplant procedures, collection and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor and other services	0% coinsurance after deductible is met	30% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 120 visits per benefit period. Limit is combined In-Network and Non-Network. Limits are combined for home health care and private duty nursing.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Limit is combined for rehabilitative and habilitative services. Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined for In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital *Limit is combined for rehabilitative and habilitative services. Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Visit limits are combined both across outpatient and other professional visits. Limit is combined for In-Network and Non-Network.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	$50 copay per visit after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to 36 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Pulmonary rehabilitation		
Office	$50 copay per visit after deductible is met	30% coinsurance after deductible is met

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Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits. Outpatient Hospital *Coverage is limited to 20 visits per benefit period. Limit is combined In-Network and Non-Network. Visit limits are combined both across outpatient and other professional visits.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period. Limit is combined In-Network and Non-Network. Benefit includes coverage for Outpatient Rehabilitation program.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Hospice	0% coinsurance after deductible is met	Covered as In-Network
Durable Medical Equipment	0% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices *Coverage for scalp hair prosthetics and wigs after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network.*	0% coinsurance after deductible is met	30% coinsurance after deductible is met

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible
Pharmacy Out of Pocket	Combined with medical out of pocket maximum	Combined with medical out of pocket maximum
Prescription Drug Coverage *Essential Drug List* *This product has a 90-day Retail Pharmacy Network available. A 90 day supply is available at most retail pharmacies.*		
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.*	$10 copay per prescription after deductible is met (retail) and $25 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
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.*	$35 copay per prescription after deductible is met (retail) and $105 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-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.*	$75 copay per prescription after deductible is met (retail) and $225 copay per prescription after deductible is met (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

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Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 4 - Typically Specialty (brand and generic) *Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program).*	25% coinsurance up to $350 per prescription after deductible is met (retail and home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

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Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- 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.
- 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.
- 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.
- If office visit is a coinsurance, the coinsurance also applies to allergy injections.
- 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.
- 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.
- 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.
- 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.
- 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.
- A Specialist copayment is applicable to care provided by Specialists, excluding General Physicians, Internist, Pediatricians and Geriatrics or other Network Provider as allowed by the plan.

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This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

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If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 578-4441

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)

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