

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: East Central College-Anthem Blue Preferred Select \$3500

Your Network: Blue Preferred

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$3,500 person / \$7,000 family	\$5,000 person / \$10,000 family
Out-of-Pocket Limit	\$5,000 person / \$10,000 family	\$10,000 person / \$20,000 family
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person 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 per person deductible or per person out-of-pocket maximum.</p> <p>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).</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	40% coinsurance after medical deductible is met
<p><u>Virtual Care (Telemedicine / Telehealth Visits)</u></p> <p>Virtual Visits - Online visits with Doctors who also provide services in person</p> <p>Primary Care (PCP)</p> <p>Mental Health and Substance Abuse care</p>	<p>\$40 copay per visit medical deductible does not apply</p> <p>\$40 copay per visit medical deductible does not apply</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	\$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care from our Online Provider K Health, through its affiliated Provider groups	No charge	
Virtual Visits from Online Provider LiveHealth Online via www.livehealthonline.com ; our mobile app, website or Anthem-enabled device Primary Care (PCP) and Mental Health and Substance Abuse Specialist Care	\$10 copay per visit medical deductible does not apply	\$60 copay per visit medical deductible does not apply
<u>Visits in an Office</u> Primary Care (PCP) Specialist Care	\$40 copay per visit medical deductible does not apply \$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Other Practitioner Visits</u> Routine Maternity Care (Prenatal and Postnatal) Retail Health Clinic Chiropractic Services <i>Coverage is limited to 26 visits per benefit period.</i>	20% coinsurance after medical deductible is met \$40 copay per visit medical deductible does not apply 50% coinsurance medical deductible does not apply	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met Not covered
<u>Other Services in an Office</u> Allergy Testing <i>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.</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Chemo/Radiation Therapy	\$60 copay per visit medical deductible does not apply [†]	40% coinsurance after medical deductible is met
Dialysis/Hemodialysis	\$60 copay per visit medical deductible does not apply	40% coinsurance after medical deductible is met
Prescription Drugs <i>Dispensed in the office</i>	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Surgery	\$60 copay per visit medical deductible does not apply [†]	40% coinsurance after medical deductible is met
<u>Diagnostic Services</u> Lab Office Outpatient Hospital	No charge 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
X-Ray Office Outpatient Hospital	No charge 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services <i>Copay waived if admitted.</i> Emergency Room Doctor and Other Services Ambulance	 \$75 copay per visit medical deductible does not apply \$350 copay per visit medical deductible does not apply No charge 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Abuse</u> Doctor Office Visit Facility Visit Facility Fees Doctor Services	\$40 copay per visit medical deductible does not apply 20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Freestanding Surgical Center	20% coinsurance after medical deductible is met 20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met 40% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Doctor and Other Services</p> <p>Hospital</p> <p>Freestanding Surgical Center</p>	<p>20% coinsurance after medical deductible is met</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></p> <p>Facility Fees</p> <p>Human Organ and Tissue Transplants <i>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i></p> <p>Doctor and other services</p>	<p>20% coinsurance after medical deductible is met</p> <p>No Cost Share</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>
<p>Rehabilitation services <i>Coverage for Physical and Occupational Rehabilitation and Habilitation therapy is limited to 40 visits combined per benefit period. Limit includes manipulative treatment when performed by someone other than a chiropractor. Speech Therapy has no visit limit. Benefit limit does not apply to Applied Behavioral Analysis. Benefit limit does not apply when performed as part of Early Intervention.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$40 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$60 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p>Pulmonary rehabilitation <i>Coverage is limited to 20 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$60 copay per visit medical deductible does not apply</p> <p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p> <p>40% coinsurance after medical deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>
<p>Inpatient Hospice</p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>
<p>Durable Medical Equipment</p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>
<p>Prosthetic Devices <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i></p>	<p>20% coinsurance after medical deductible is met</p>	<p>40% coinsurance after medical deductible is met</p>

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<p>Pharmacy Deductible</p>	<p>Not Applicable</p>	<p>Not Applicable</p>	<p>Not Applicable</p>

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
<p>Prescription Drug Coverage Cost shares for drugs included on the Essential drug list appear below. Drugs not included on the Essential drug list will not be covered. Your plan uses the Rx Choice Tiered Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.</p>			
<p>Home Delivery Pharmacy Maintenance medication are available through IngenioRx Home Delivery Pharmacy. You may get two 30-day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must call us on the number on your ID card and tell us if you would like to keep getting your maintenance medications from a retail pharmacy or if you would like to use home delivery. If you do not contact us, you will pay the full retail cost of any maintenance medication until you inform us of your decision.</p>			
<p>Tier 1 - Typically Generic Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p>	<p>\$15 copay per prescription, Pharmacy deductible does not apply (retail) and \$30 copay per prescription, Pharmacy deductible does not apply (home delivery)</p>	<p>\$25 copay per prescription, Pharmacy deductible does not apply (retail) and Not covered (home delivery)</p>	<p>50% coinsurance, Pharmacy deductible does not apply (retail) and Not covered (home delivery)</p>
<p>Tier 2 – Typically Preferred Brand Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p>	<p>\$40 copay per prescription after Pharmacy deductible is met (retail) and \$80 copay per prescription after Pharmacy deductible is met (home delivery)</p>	<p>\$50 copay per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)</p>	<p>50% coinsurance after Pharmacy deductible is met (retail) and Not covered (home delivery)</p>
<p>Tier 3 - Typically Non-Preferred Brand Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).</p>	<p>\$75 copay per prescription after Pharmacy deductible is met (retail) and \$150 copay per prescription after Pharmacy deductible is met (home delivery)</p>	<p>\$85 copay per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)</p>	<p>50% coinsurance after Pharmacy deductible is met (retail) and Not covered (home delivery)</p>
<p>Tier 4 - Typically Specialty (brand and generic) Per 30 day supply (specialty pharmacy).</p>	<p>25% coinsurance up to \$350 per prescription after Pharmacy deductible is met (retail and home delivery)</p>	<p>25% coinsurance up to \$450 per prescription after Pharmacy deductible is met (retail) and Not covered (home delivery)</p>	<p>50% coinsurance after Pharmacy deductible is met (retail) and Not covered (home delivery)</p>

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider	
<i>This is a brief outline of your vision coverage. Only children's vision services count towards your out of pocket limit.</i>			
<u>Children's Vision (up to age 19)</u>			
Child Vision Deductible	\$0 person	\$0 person	
Vision exam <i>Limited to 1 exam per benefit period.</i>	No charge	\$0 copayment up to plan's Maximum Allowed Amount	
<u>Adult Vision (age 19 and older)</u>			
Adult Vision Deductible	\$0 person	\$0 person	
Vision exam <i>Limited to 1 exam per benefit period.</i>	No charge	Reimbursed Up to \$42	

Notes:

- Dependent age: to end of the month in which the child attains age 26.
- 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.
- 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.
- The representations of benefits in this document are subject to Division of Insurance approval and are subject to change.
- 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.
- † Your cost share will be reduced when services are provided in a PCP's office.

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.

Your Plan: East Central College-Anthem Blue Preferred Select \$3500

Your Network: Blue Preferred

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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Questions: (833) 578-4436 or visit us at www.anthem.com

MO/LG/East Central College-Anthem Blue Preferred Select \$3500//01-01-2022

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 (833) 578-4436

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)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 578-4436.

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՝ (833) 578-4436:

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(833) 578-4436。

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادریتان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 578-4436 تماس بگیرید.

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 (833) 578-4436.

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 (833) 578-4436.

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 (833) 578-4436.

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Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee nił hodoonih t'áadoo bǫ́ǫ́h ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninizingo kojí' hodíílnih (833) 578-4436.

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: (833) 578-4436.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 578-4436 ਤੇ ਕਾਲ ਕਰੋ।

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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 (833) 578-4436.

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 (833) 578-4436.

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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>.