

Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Blue Preferred Plus POS HSA Option E8

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	\$2,800 person / \$5,600 family	\$5,600 person / \$11,200 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 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.</p>		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after deductible is met
<u>Doctor Home and Office Services</u>		
Primary Care Visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Specialist Care Visit	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prenatal and Post-natal Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Practitioner Visits:</u>		
Retail Health Clinic	20% coinsurance after deductible is met	40% coinsurance after deductible is met
On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Manipulation Therapy	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Services in an Office:</u>		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Allergy Testing	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Chemo/Radiation Therapy	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Dialysis/Hemodialysis	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prescription Drugs - <i>Dispensed in the office</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab: Office Outpatient Hospital	 20% coinsurance after deductible is met 20% coinsurance after deductible is met	 40% coinsurance after deductible is met 40% coinsurance after deductible is met
X-Ray: Office Outpatient Hospital	 20% coinsurance after deductible is met 20% coinsurance after deductible is met	 40% coinsurance after deductible is met 40% coinsurance after deductible is met
Advanced Diagnostic Imaging: Office Freestanding Radiology Center Outpatient Hospital	 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	 40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Emergency and Urgent Care</u> Urgent Care	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Emergency Room Facility Services Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
<u>Ambulance</u>	20% coinsurance after deductible is met	Covered as In-Network
<u>Outpatient Mental/Behavioral Health and Substance Abuse</u> Doctor Office Visit Facility Visit: Facility Fees Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees: Hospital Freestanding Surgical Center Doctor and Other Services: Hospital Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Hospital (Including Maternity, Mental / Behavioral Health, 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 deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after 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 deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Rehabilitation services:</p> <p>Office <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 40 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 40 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation</p> <p>Office <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Outpatient Hospital <i>Coverage is limited to 36 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage is limited to 30 days per admission.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Hospice</p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	Combined with In-Network medical deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
Pharmacy Out of Pocket	Combined with In-Network medical	Combined with In-Network medical	Combined with Non-Network medical

Prescription Drug Coverage

Rx Choice Tiered Network w/R90

Essential Drug List

This product has a 90-day Retail Pharmacy Network available. No coverage for non-formulary drugs.

Preventive Drugs

Preventive Rx Plus: Deductible is waived for certain drugs for diabetes, asthma, heart health, high blood pressure, high cholesterol, stroke, and osteoporosis. This plan has Preventive RX coverage that allows the cost share without application to Deductible for designated Preventive drugs.

Tier 1 - Typically Generic	20% coinsurance, deductible does not apply (retail and home delivery)	20% coinsurance, deductible does not apply (retail and home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	20% coinsurance, deductible does not apply (retail and home delivery)	20% coinsurance, deductible does not apply (retail and home delivery)	40% coinsurance, deductible does not apply (retail) and Not covered (home delivery)
Tier 1 - Typically Generic <i>30 day supply (retail pharmacy). 90 day supply (home delivery).</i>	20% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Tier 2 – Typically Preferred Brand 30 day supply (retail pharmacy). 90 day supply (home delivery).	20% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand 30 day supply (retail pharmacy). 90 day supply (home delivery).	20% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) 30 day supply (retail pharmacy). 30 day supply (home delivery).	20% coinsurance after deductible is met (retail and home delivery)	30% coinsurance after deductible is met (retail) and Not covered (home delivery)	40% coinsurance after deductible is met (retail) and Not covered (home delivery)

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.
- All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- If your plan includes out-of-network benefits, In-network and out-of-network deductibles, copayments, coinsurance and out-of-pocket maximum amounts are separate and do not accumulate toward each other.
- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services” which is generally coinsurance or coinsurance after your deductible is met.

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.

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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

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin (BCBSWi), CompCare Health Services Insurance Corporation (CompCare) and Wisconsin Collaborative Insurance Company (WCIC). BCBSWi underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare or WCIC; CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Questions: (833) 578-4439 or visit us at www.anthem.com

WI/LG/Anthem Blue Preferred Plus POS HSA Option E8/5UYX/01-01-2021

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) 578-4439

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) 578-4439.

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) 578-4439:

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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) 578-4439.

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) 578-4439.

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Language Access Services:

Navajo (Diné): Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehj̄ bee nił hodoonih t'áadoo bą́ąh ilínígóó. Ata' halne'ígíí la' bich'į' hadeesdzih ninizingo kojį' hodíilnih (833) 578-4439.

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) 578-4439.

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It's important we treat you fairly

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