Your Anthem Benefits

Anthem

EPC- Riverside
Blue Access℠ for Lumenos Health Savings Accounts
Summary of Benefits, Effective 1/1/2021

Please note: As we receive additional guidance and clarification from the U.S. Department of Health and Human Services, we may be required to make additional changes to your benefits. At this time, we do not expect rates to be impacted by these changes.

Covered Benefits	Network	Non-Network
Deductible *Family coverage requires the family deductible to be met before coinsurance applies. The single deductible does not apply to family coverage. (This only applies to non-embedded deductible designs.)*	Single: $2,000 Family: $4,000	Single: $2,000 Family: $4,000
Out-of-Pocket Limit	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Physician Home and Office Services (PCP/SCP) Primary Care Physician (PCP)/Specialty Care Physician (SCP) • Including Office Surgeries, allergy serum, allergy injections and allergy testing	0%	30%
Preventive Care Services Services include but are not limited to: Routine Exams, Pelvic Exams, Pap testing, PSA tests, Immunizations, Annual diabetic eye exam, Routine Vision and Hearing exams, Routine Mammograms, Diabetic Education and Certain Medical Nutritional Therapy (Network only) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility	 No copayment/coinsurance No copayment/coinsurance	 30% 30%
Emergency and Urgent Care • Emergency Room Services @ Hospital (facility/other covered services) *(copayment waived if admitted)* • Urgent Care Center Services	 0% 0%	 0% 0%
Inpatient and Outpatient Professional Services Include but are not limited to: • Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams	0%	30%
Inpatient Facility Services Unlimited days except for: • 60 days Network/Non-Network combined for physical medicine/rehab (limit includes Day Rehabilitation Therapy Services on an outpatient basis) • 90 days Network/Non-Network combined for skilled nursing facility	0%	30%
Outpatient Surgery Hospital/Alternative Care Facility • Surgery and administration of general anesthesia	0%	30%
Other Outpatient Services *(including but not limited to):* • Non Surgical Outpatient Services For example: MRIs, C-Scans, Chemotherapy, Ultrasounds and other diagnostic outpatient services. • Home Care Services (Network/Non-network combined) 90 visits (excludes IV Therapy) • Durable Medical Equipment and Orthotics (Network/Non-network combined) • Prosthetic Devices • Physical Medicine Therapy Day Rehabilitation programs • Hospice Care • Ambulance Services	0% 0% 0%	30% 0% 0%

Covered Benefits	Network	Non-Network
Outpatient Therapy Services (Combined Network & Non-Network limits apply) • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services @ Hospital/Alternative Care Facility Limits apply to: • Physical therapy: 20 visits • Occupational therapy: 20 visits • Manipulation therapy: 12 visits • Speech therapy: 20 visits	 0% 0%	 30% 30%
Behavioral Health Services • Inpatient Facility Services • Inpatient Professional Services • Physician Home and Office Visits (PCP/SCP) • Other Outpatient Services. Outpatient Facility @ Hospital/Alternative Care Facility, Outpatient Professional	 0% 0% 0% 0%	 30% 30% 30% 30%
Human Organ and Tissue Transplants • Acquisition and transplant procedures, harvest and storage.	0%	30%
Prescription Drugs **Administered by CVS/Caremark**	See Your Prescription Benefits Summary	See Your Prescription Benefits Summary
Lifetime Maximum (Combined Network and Non-network)	Unlimited	Unlimited

Notes:
- *All deductibles and coinsurance apply toward the out-of-pocket maximum including prescription drugs. (Excludes Non-network Human Organ and Tissue Transplants).*
- *Deductible(s) apply to covered services listed with a percentage (%) coinsurance including prescription drugs and may not apply to some Behavioral Health services where coinsurance applies.*
- *Network and Non-network deductibles are combined. Network and Non-network coinsurance and out of pocket maximums are separate and do no accumulate towards each other.*
- *Dependent Age: to the end of the month which the child attains age 26.*
- *No copayment/coinsurance 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.*
- *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.*
- *Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.*
- *Benefit period = calendar year*

[1]*We encourage you to contact Our Mental Health Subcontractor to assure the use of appropriate procedures, setting and medical necessity. Refer to Schedule of Benefits for limitations. Behavioral Health Services (Mental Health and Substance Abuse) benefits provided in accordance with Federal Mental Health parity.*
[2]*Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.*
[3]*Prescription Drugs do not accumulate toward the Medical Lifetime Maximum. However, once the Medical Lifetime Maximum is met, no additional Prescription Drug claims will be paid.*

Precertification:
- *Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help avoid any unnecessary reduction in benefits for non-covered or non-medically necessary services.*

Pre-existing Exclusion Period: None

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.

Here's an overview of your CVS Caremark benefits.

Riverside HDHP 1/1/2021

Your annual deductible is $2,000 for an individual or $4,000 for a family. **Until this deductible amount is met, you will pay 100% for your prescriptions**. If you have any questions about your prescription plan or costs, call us at 1-888-202-1654. We can help anytime after your plan starts. For TDD assistance, please call 1-800-863-5488.

	Short-Term Medicines CVS Caremark Retail Pharmacy Network (Up to a 30-day supply)	**Long-Term Medicines** CVS Caremark Mail Service Pharmacy or CVS Pharmacy Locations (Up to a 90-day supply)
Generic Medicines Always ask your doctor if there's a generic option available. It could save you money.	**$0 after deductible** for a generic medicine	**$0 after deductible** for a generic medicine
Preferred Brand-Name Medicines If a generic is not available or appropriate, ask your doctor to prescribe from your plan's preferred drug list.	**$0 after deductible** for a preferred brand-name medicine	**$0 after deductible** for a preferred brand-name medicine
Non-Preferred Brand-Name Medicines Drugs that aren't on your plan's preferred list will cost more.	**$0 after deductible** for a non-preferred brand-name medicine	**$0 after deductible** for a non-preferred brand-name medicine
Refill Limit	**None**	**None**
Maximum Out-of-Pocket	**$2,000 per individual / $4,000 per family (combined with medical)**	
Annual Deductible	**$2,000 per individual / $4,000 per family (combined with medical)**	
Specialty Medicines	Specialty medications are required to be filled through CVS Specialty Mail Order Pharmacy or at a retail CVS/pharmacy. Please contact Customer Care toll-free at 1-888-202-1654 for questions or to get started today.	
Prior Authorization	Certain medications may require prior authorization. Please contact Customer Care toll-free at 1-888-202-1654 or visit www.caremark.com for verification of prior authorization requirements.	

Please Note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the brand copayment.

Copayment, copay or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.
Your feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-202-1654.
If you access your pharmacy benefits information through the Caremark Web site, you can find Plan Members Rights and Responsibilities at www.caremark.com.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle private health information.

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Notice of Nondiscrimination

Federal civil rights laws prohibit certain health programs and activities from discriminating on the basis of race, color, national origin, age, disability, or sex. The laws apply to health programs and activities that receive funding from the Federal government, are administered by a Federal agency or are offered on a public Health Insurance Marketplace. Health plans that are subject to the laws include Medicare Part D plans, Medicaid plans, health plans offered by issuers on Health Insurance Marketplaces, and certain employee health benefit plans. If you have questions about whether these Federal civil rights laws apply to your plan, please contact your health plan at the number in your benefit plan materials.

If your health plan is subject to these Federal civil rights laws, it complies with the laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex and does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Your health plan:

- Provides appropriate aids and services, free of charge, when necessary to ensure that people with disabilities have an equal opportunity to communicate effectively with us, such as:
  - Auxiliary aids and services
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides language assistance services, free of charge, when necessary to provide meaningful access to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Customer Care at the phone number on your benefit ID card.

If you believe these services have not been appropriately provided to you or you have been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail, fax, or email with your health plan's Civil Rights Coordinator.

You may also contact Customer Care and we will direct your grievance to your health plan's Civil Rights Coordinator:

Nondiscrimination Grievance Coordinator
PO BOX 6590, Lee's Summit, MO 64064-6590
Phone: 1-866-526-4075
TTY: 1-800-863-5488
Fax: 1-855-245-2135
Email: nondiscrimination@cvscaremark.com

If you need additional help filing a grievance, your health plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.