

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

EPC - Miamisburg HSA (with Copay)

Your Network: Blue Access PPO

Effective Date 1/1/2024

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$2,000 person / \$4,000 family	\$4,000 person / \$8,000 family
<b>Out-of-Pocket Limit</b>	\$3,000 person / \$6,000 family	\$6,000 person / \$12,000 family
The family deductible and out-of-pocket maximum are non-embedded meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The individual deductible and individual out-of-pocket maximum only apply to individuals enrolled under single coverage.		
<b>Preventive Care / Screening / Immunization</b>	No charge	30% coinsurance after deductible is met
<b><u>Doctor Home and Office Services</u></b>  <b>Primary Care Visit</b> <i>When Allergy injections are billed separately by network providers, the member is responsible for \$5 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.</i>	\$25 copay per visit after deductible is met	30% coinsurance after deductible is met
<b>Specialist Care Visit</b> <i>When Allergy injections are billed separately by network providers, the member is responsible for \$5 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.</i>	\$50 copay per visit after deductible is met	30% coinsurance after deductible is met
<b>Prenatal and Post-natal Care</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b><u>Other Practitioner Visits:</u></b>  Medical Chats - <i>within our mobile app</i>  Retail Health Clinic	0% coinsurance after deductible is met  \$25 copay per visit after deductible is met	Not Applicable  30% 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 <i>Includes Mental/Behavioral Health and Substance Abuse</i>	\$25 copay per visit after deductible is met	30% coinsurance after deductible is met
Other Participating Provider On-line Visit <i>Includes Mental/Behavioral Health and Substance Abuse</i>	\$25 copay per visit after deductible is met	30% coinsurance after deductible is met
Manipulation Therapy <i>Coverage is limited to 12 visits per benefit period.</i>	\$50 copay per visit after deductible is met	30% coinsurance after deductible is met
<b><u>Other Services in an Office:</u></b> Allergy Testing  Chemo/Radiation Therapy  Dialysis/Hemodialysis  Prescription Drugs - <i>Dispensed in the office</i>	0% coinsurance after deductible is met  0% coinsurance after deductible is met  \$60 copay per visit after deductible is met  0% coinsurance after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b><u>Diagnostic Services</u></b> <b>Lab:</b> Office  Outpatient Hospital	0% coinsurance after deductible is met  0% coinsurance after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b>X-Ray:</b> Office  Outpatient Hospital	0% coinsurance after deductible is met  0% coinsurance after deductible is met	30% coinsurance after deductible is met  30% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging:</b> Office	0% coinsurance after deductible is met	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b>  <i>When Allergy injections are billed separately by network providers, the member is responsible for \$5 copay after deductible is met. When billed as part of an office visit, there is no additional cost to the member for the injection.</i></p>	\$50 copay per visit after deductible is met	30% coinsurance after deductible is met
<p><b>Emergency Room Facility Services</b></p> <p><b>Emergency Room Doctor and Other Services</b></p>	<p>\$100 copay per visit and 0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p>
<b><u>Ambulance</u></b>	0% coinsurance after deductible is met	Covered as In-Network
<p><b><u>Outpatient Mental/Behavioral Health and Substance Abuse</u></b></p> <p><b>Doctor Office Visit</b></p> <p><b>Facility Visit:</b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$25 copay per visit after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees:</b></p> <p>Hospital</p> <p><b>Doctor and Other Services:</b></p> <p>Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% 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
<p><b><u>Hospital (Including Maternity, Mental / Behavioral Health, Substance Abuse):</u></b></p> <p><b>Facility Fees</b></p> <p><b>Human Organ and Tissue Transplants</b> <i>Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.</i></p> <p><b>Doctor and other services</b></p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b><u>Recovery &amp; Rehabilitation</u></b></p> <p><b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period. Private Duty Nursing is limited to 82 visits/Calendar Year.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Rehabilitation services:</b></p> <p>Office <i>Coverage for Occupational Therapy, Physical Therapy is limited to 60 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined for rehabilitative and habilitative services.</i></p> <p>Outpatient Hospital <i>Coverage for Occupational Therapy, Physical Therapy is limited to 60 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined for rehabilitative and habilitative services.</i></p>	<p>\$50 copay per visit after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b></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>\$50 copay per visit after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><b>Skilled Nursing Care (facility)</b> <i>Coverage for Skilled Nursing is limited to 90 visits per benefit period. And Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 60 days per benefit period.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p><b>Hospice</b></p>	<p>0% coinsurance after deductible is met</p>	<p>0% 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
<b>Durable Medical Equipment</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Prosthetic Devices</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Prescription Drugs:</b>	See Your Prescription	See Your Prescription
<b>Administered by CVS/Caremark</b>	Benefit Plan Summary	Benefit Plan Summary

**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.
- The Primary Care Physician and Specialist office visit copay applies to both office and facility based office visits for evaluation and management services only.
- 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 may be reduced when services are provided in a PCP's office.
- If you have receive 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 Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.*

Your Plan: Anthem Blue Access HSA (with Copay)

Your Network: Blue Access PPO

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.

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Questions: (833) 639-1634 or visit us at [www.anthem.com](http://www.anthem.com)

OH/LG/Anthem Blue Access PPO HSA (with Copay) Option 1 with Rx Option T8/62Q8/01-01-2021

## 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) 639-1634

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) 639-1634.

**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) 639-1634:

**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) 639-1634。

**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) 639-1634 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) 639-1634.

**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) 639-1634.

**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) 639-1634.

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(833) 639-1634 にお電話ください。

## Language Access Services:

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 639-1634로 문의하십시오.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idiikidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nií hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninízingo kojí' hodiílnih (833) 639-1634.

**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) 639-1634.

**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 ਦੁਬਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (833) 639-1634 ਤੇ ਕਾਲ ਕਰੋ।

**Russian (Русский):** если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (833) 639-1634.

**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) 639-1634.

**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) 639-1634.

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 639-1634.

### 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>.



# Here's an overview of your CVS Caremark benefits.

## Miamisburg HDHP with Copays- 1/1/2024

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.

	<b>Short-Term Medicines</b> CVS Caremark Retail Pharmacy Network (Up to a 30-day supply)	<b>Long-Term Medicines</b> CVS Caremark Mail Service Pharmacy or CVS Pharmacy Locations (Up to a 90-day supply)
<b>Generic Medicines</b> Always ask your doctor if there's a generic option available. It could save you money.	<b>\$10 copay after deductible</b> for a generic medicine	<b>\$20 copay after deductible</b> for a generic medicine
<b>Preferred Brand-Name Medicines</b> If a generic is not available or appropriate, ask your doctor to prescribe from your plan's preferred drug list.	<b>\$20 copay after deductible</b> for a preferred brand-name medicine	<b>\$30 copay after deductible</b> for a preferred brand-name medicine
<b>Non-Preferred Brand-Name Medicines</b> Drugs that aren't on your plan's preferred list will cost more.	<b>\$30 copay after deductible</b> for a non-preferred brand-name medicine	<b>\$40 copay after deductible</b> for a non-preferred brand-name medicine
<b>Refill Limit</b>	<b>One initial fill plus two additional refills for long-term medications</b>	<b>None</b>
<b>Maximum Out-of-Pocket</b>	<b>\$3,000 per individual / \$6,000 per family (combined with medical)</b>	
<b>Annual Deductible</b>	<b>\$2,000 per individual / \$4,000 per family (combined with medical)</b>	
<b>Specialty Medicines</b>	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.	
<b>Prior Authorization</b>	Certain medications may require prior authorization. Please contact Customer Care toll-free at 1-888-202-1654 or visit <a href="http://www.caremark.com">www.caremark.com</a> for verification of prior authorization requirements.	

Please Note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason other than doctor or other prescriber indicates "dispense as written," 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](http://www.caremark.com).

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Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your 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](mailto: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>.