

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

**Millennia Housing Management, LTD**

Your Plan: Anthem Blue Access PPO HSA (with Copay)

Your Network: Blue Access

**Effective Date: 08/01/2023**

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$3,000 person / \$6,000 family	\$9,000 person / \$18,000 family
<b>Overall Out-of-Pocket Limit</b>	\$4,000 person / \$8,000 family	\$12,000 person / \$24,000 family
<p>The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.</p> <p>All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket limit(s) (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).</p> <p>In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
<b>Doctor Visits (virtual and office)</b> <i>You are encouraged to select a Primary Care Physician (PCP).</i>		
<b>Medical Chats and Virtual Visits for Primary Care</b> <i>from our Online Provider K Health, through its affiliated Provider groups are covered at No charge after deductible is met.</i>		
<b>Virtual Visits from online provider LiveHealth Online</b> <i>for urgent/acute medical and mental health and substance abuse care via <a href="http://www.livehealthonline.com">www.livehealthonline.com</a> are covered at No charge after deductible is met; and \$60 copay per visit after deductible is met for covered Specialist Care.</i>		
<b>Primary Care (PCP) and Mental Health and Substance Abuse Care</b> <i>virtual and office</i>	\$30 copay per visit after deductible is met	30% coinsurance after deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	\$60 copay per visit after deductible is met	30% coinsurance after deductible is met
<b><u>Other Practitioner Visits</u></b>		
<b>Routine Maternity Care</b> (Prenatal and Postnatal)	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
<b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i>	\$30 copay per visit after deductible is met	30% coinsurance after deductible is met
<b>Manipulation Therapy</b> <i>Coverage is limited to 12 visits per benefit period.</i>	\$60 copay per visit after deductible is met	30% coinsurance after deductible is met
<b><u>Other Services in an Office</u></b> <b>Allergy Testing</b> <i>When Allergy injections are billed separately by network providers, the member is responsible for a \$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.</i> <b>Prescription Drugs</b> <i>Dispensed in the office</i> <b>Surgery</b>	0% coinsurance after deductible is met  0% coinsurance after deductible is met \$60 copay per visit after deductible is met <sup>‡</sup>	30% coinsurance after deductible is met  30% coinsurance after deductible is met 30% coinsurance after deductible is met
<b>Preventive care / screenings / immunizations</b>	No charge	30% coinsurance after deductible is met
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	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> <i>for example: MRI, PET and CAT scans</i>  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

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b><u>Emergency and Urgent Care</u></b> <b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i>  <b>Emergency Room Facility Services</b>  <b>Emergency Room Doctor and Other Services</b>  <b>Ambulance</b>	\$75 copay per visit after deductible is met  \$350 copay per visit and 0% coinsurance after deductible is met  0% coinsurance after deductible is met  0% coinsurance after deductible is met	30% coinsurance after deductible is met  Covered as In-Network  Covered as In-Network  Covered as In-Network
<b><u>Outpatient Mental Health and Substance Abuse Care at a Facility</u></b> Facility Fees  Doctor Services	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><u>Outpatient Surgery</u></b> <b>Facility Fees</b> Hospital  <b>Doctor and Other Services</b> 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><u>Hospital (Including Maternity, Mental Health and Substance Abuse)</u></b>  <b>Facility Fees</b>  <b>Human Organ and Tissue Transplants</b> <i>Cornea transplants are treated the same as any other illness and subject to the medical benefits.</i> <b>Physician and other services</b> <i>including surgeon fees</i>	0% coinsurance after deductible is met  0% coinsurance 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
<b>Home Health Care &amp; Private Duty Nursing</b> <i>Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.</i>	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
<b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i> <i>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.</i>		
Office	\$60 copay per visit after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Pulmonary rehabilitation</b> <i>Coverage is limited to 20 visits per benefit period.</i>		
Office	\$60 copay per visit after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Cardiac rehabilitation</b> <i>Coverage is limited to 36 visits per benefit period.</i>		
Office	\$60 copay per visit after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Dialysis/Hemodialysis</b>		
Office	\$60 copay per visit after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Chemo/Radiation Therapy</b>		
Office	\$60 copay per visit after deductible is met <sup>‡</sup>	30% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Skilled Nursing Care (facility)</b>	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
<i>Coverage for Skilled Nursing is limited to 100 days per benefit period. Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 60 days per benefit period.</i>		
<b>Inpatient Hospice</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	0% coinsurance after deductible is met	30% coinsurance after deductible is met
<b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	0% coinsurance after deductible is met	30% coinsurance after deductible is met

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
<b>Pharmacy Deductible</b>	Combined with In-Network medical deductible	Combined with In-Network medical deductible	Combined with Non-Network medical deductible
<b>Pharmacy Out-of-Pocket Limit</b>	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
<b>Prescription Drug Coverage</b> <b>Network: Rx Choice Tiered Network</b> <b>Drug List: Essential</b> Drugs not included on the Essential drug list will not be covered.			
<b>Day Supply Limits:</b> <b>Retail Pharmacy</b> 30 day supply (cost shares noted below) <b>Retail 90 Pharmacy</b> 90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies). <b>Home Delivery Pharmacy</b> 90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service. <b>Specialty Pharmacy</b> 30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy.			
<b>Tier 1 - Typically Generic</b>	\$10 copay per prescription after deductible is met (retail) and \$25 copay per prescription after deductible is met (home delivery)	\$20 copay per prescription after deductible is met (retail) and Not covered (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)

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
<b>Tier 2 – Typically Preferred Brand</b>	\$40 copay per prescription after deductible is met (retail) and \$120 copay per prescription after deductible is met (home delivery)	\$50 copay per prescription after deductible is met (retail) and Not covered (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b>	\$70 copay per prescription after deductible is met (retail) and \$210 copay per prescription after deductible is met (home delivery)	\$80 copay per prescription after deductible is met (retail) and Not covered (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b>	25% coinsurance up to \$350 per prescription after deductible is met (retail and home delivery)	25% coinsurance up to \$450 per prescription after deductible is met (retail) and Not covered (home delivery)	50% coinsurance after deductible is met (retail) and Not covered (home delivery)
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. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out of pocket limit.</i>			
<b>Children's Vision exam (up to age 19)</b> <i>Limited to 1 exam per benefit period.</i>		No charge	\$0 copayment up to plan's Maximum Allowed Amount
<b>Adult Vision exam (age 19 and older)</b> <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 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 will be reduced when services are provided in a PCP's office.
- If you have received 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.
- Ohio's House Bill 388 and the Federal No Surprises Act establish patient protections including from Out-of-Network Providers' surprise bills ("balance billing") for Emergency Care and other specified items or services. We will comply with these new state and federal requirements including how we process claims from certain Out-of-Network Providers.
- Benefit Period: Calendar Year

*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 summary of benefits



Your Plan: Anthem Blue Access PPO HSA (with Copay) \$3,000

Your Network: Blue Access

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

OH/LG/Anthem Blue Access PPO HSA (with Copay) \$3,000/08-01-2023



### 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。

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**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.

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## Language Access Services:

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'ídiikidgo ná bohónéedzǫ́ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee níl hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínízingo 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 ਦੁਭਾਸ਼ੀਏ 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.

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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>.