

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your Plan: Truman State University: Anthem Blue Access PPO Plan A

Your Network: Blue Access

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge
Mental Health & Substance Use Disorder Services	No charge
Specialist care	\$35 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Overall Deductible</b>	\$750 person / \$1,500 family	\$1,500 person / \$3,000 family
<b>Overall Out-of-Pocket Limit</b> <i>The out-of-pocket costs you pay for prescription drugs obtained at a pharmacy will apply to a separate Pharmacy Out-of-Pocket Limit. See the Covered Prescription Drug Benefits section.</i>	\$2,500 person / \$5,000 family	\$6,000 person / \$12,000 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 deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding prescription drug).</p> <p>In-Network and Out-of-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
<p><b>Doctor Visits (virtual and office)</b> <i>You are encouraged to select a Primary Care Physician (PCP). For members up to age 19, visits with In-Network Providers for primary care, and mental health and substance use disorder services are covered at no charge.</i></p>		
<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	\$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	\$35 copay per visit deductible does not apply	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><b><u>Other Practitioner Visits</u></b></p> <p><b>Maternity Doctor services</b> (prenatal/postnatal care and delivery)</p> <p><b>Retail Health Clinic</b> <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p> <p><b>Chiropractic Services</b> <i>Coverage is limited to 26 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p> <p>\$25 copay per visit deductible does not apply</p> <p>\$25 copay per visit deductible does not apply</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b><u>Other Services in an Office</u></b></p> <p><b>Allergy Testing</b> <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></p> <p><b>Prescription Drugs</b> <i>Dispensed in the office</i></p> <p><b>Surgery</b></p>	<p>\$10 copay per visit deductible does not apply</p> <p>No charge</p> <p>\$35 copay per visit deductible does not apply<sup>†</sup></p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b>Preventive care / screenings / immunizations</b></p>	<p>No charge</p>	<p>50% coinsurance after deductible is met</p>
<p><b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i></p>	<p>No charge</p>	<p>50% coinsurance after deductible is met</p>
<p><b><u>Diagnostic Services</u></b></p> <p><b>Lab</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b>X-Ray</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>No charge</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><b>Advanced Diagnostic Imaging</b> <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</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>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b> <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p><b>Emergency Room Facility Services</b> <i>Your copay will be waived if admitted.</i></p> <p><b>Emergency Room Doctor and Other Services</b></p> <p><b>Ambulance</b> <i>Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip.</i></p>	<p>\$50 copay per visit deductible does not apply</p> <p>\$200 copay per visit deductible does not apply</p> <p>\$200 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p><b>Physician and other services</b> <i>including surgeon fees</i></p> <p>Hospital</p> <p>Ambulatory Surgical Center</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>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><b><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</u></b></p> <p><b>Facility Fees</b></p> <p><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></p> <p><b>Physician and other services</b> <i>including surgeon fees</i></p>	<p>20% coinsurance after deductible is met</p> <p>No charge</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b>Home Health Care</b> <i>Coverage is limited to 100 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p><b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical and occupational therapies is limited to 44 visits combined per benefit period. Limit includes manipulative treatment when performed by someone other than a Chiropractor. Benefit limit does not apply when performed as part of Early Intervention.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b>Pulmonary rehabilitation</b></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$35 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b>Cardiac rehabilitation</b> <i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$35 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><b>Dialysis/Hemodialysis</b></p>		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
Office  Outpatient Hospital	\$35 copay per visit deductible does not apply  20% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b>Chemo/Radiation Therapy</b>  Office  Outpatient Hospital	\$35 copay per visit deductible does not apply <sup>†</sup>  20% coinsurance after deductible is met	50% coinsurance after deductible is met  50% coinsurance after deductible is met
<b>Skilled Nursing Care (facility)</b> <i>Coverage is limited to 100 days per benefit period.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Inpatient Hospice</b>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Durable Medical Equipment</b>	20% coinsurance after deductible is met	50% 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>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<b>Hearing Aids</b> <i>Coverage for hearing aids is limited to children 1 through 17 years of age, with one hearing aid per ear every 36 months. Newborn hearing aids no limit.</i>	20% coinsurance after deductible is met	50% coinsurance after deductible is met
Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<b>Pharmacy Deductible</b>	Not applicable	Not applicable
<b>Pharmacy Out-of-Pocket Limit</b>	\$2,000 person / \$3,000 family	Unlimited
<b>Prescription Drug Coverage</b> <b>Network: Base Network</b> <b>Drug List: Essential</b> Drugs not included on the Essential drug list will not be covered.		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<p><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 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 our home delivery pharmacy. 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. Drug cost share assistance programs may be available for certain specialty drugs.</p>		
Tier 1 - Typically Generic	\$15 copay per prescription (retail) and \$30 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 2 - Typically Preferred Brand	\$30 copay per prescription (retail) and \$60 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand	\$60 copay per prescription (retail) and \$120 copay per prescription (home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 4 - Typically Preferred Specialty (brand and generic)	20% coinsurance up to \$200 per prescription (retail and home delivery)	50% coinsurance (retail) and Not covered (home delivery)
Tier 5 - Typically Non-Preferred Specialty (brand and generic)	20% coinsurance up to \$250 per prescription (retail and home delivery)	50% coinsurance (retail) and Not covered (home delivery)

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<i>This is a brief outline of your vision coverage.</i>		
Children's Vision exam	No charge	50% coinsurance after deductible is met
Adult Vision exam	No charge	50% coinsurance after deductible is met

## Notes:

- Dependent Age Limit: to the end of the year in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using Out-of-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 an Out-of-Network Provider, the member is responsible for any balance due after the plan payment.
- 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.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full as required by state mandate.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.
- ‡ You will pay the PCP's office visit copay when services are provided in their 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.*

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

## Language Access Services:

### 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.

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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) 578-4436.

**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.

**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) 578-4436 にお電話ください。

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(833) 578-4436로 문의하십시오.

**Navajo (Diné):** Díí naaltsoos biká'ígíí lahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee níl hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih ninízingo kojí' hodiłlnih (833) 578-4436.



## Language Access Services:

**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।

**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) 578-4436.

**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.

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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>.