Your Summary of Benefits

PPO

WSWHE Counties Health Insurance Consortium Trust

Benefit	In-Network [1]	Out-of-Network [2,3]
Deductible	N/A	$200/$500
Coinsurance	N/A	20%
Out-of-Pocket Maximum	$5,080 / $12,700 (All In-Network Medical & RX Cost Shares)	$5,000/$12,500 Coinsurance Stop Loss / $1,200 / $3,000 Out-of-Pocket Maximum
Lifetime Maximum	Unlimited	Unlimited
Dependent Children (covered to the end of the month of the dependent's birthday)	Dependents to age 26	Dependents to age 26
Covered Preventive Care[4]	**Member Pays In-Network**	**Member Pays Out-of-Network**
Covered Adult Preventive Care	$0	Deductible and Coinsurance
Annual Physical Exam	$0	Covered in-network only
Well-Child Care (Up to age 19; including necessary covered immunizations)	$0	Deductible and Coinsurance
Preventive Well-Woman Care	$0	Deductible and Coinsurance
Home/Office/Outpatient Care	**Member Pays In-Network**	**Member Pays Out-of-Network**
Home/Office Visits / Online Visits	$10 copayment	Deductible and Coinsurance
Urgent Care Center	$10 copayment	$10 copayment
Emergency Room/Facility (initial visit per occurrence)	$35 copayment (Waived if admitted within 24 hours)	$35 copayment (Waived if admitted within 24 hours)
Surgery[5], Presurgical Testing, Anesthesia	$0	Deductible and Coinsurance
Chemotherapy, Radiation Therapy	$0	Deductible and Coinsurance
Routine Maternity Care	$0	Deductible and Coinsurance
Laboratory Tests, X-rays	$0	Deductible and Coinsurance
MRI/MRA[6], CAT Scan[7], PET[7] & Nuclear Cardiology[7]	$0	Deductible and Coinsurance
Allergy Routine Testing and Treatment (Allergy Injections/Immunotherapy)	$10 copayment (Waived for treatment)	Deductible and Coinsurance
Chiropractic Care[9]	$10 copayment	Deductible and Coinsurance
Home Healthcare (Up to 200 visits per calendar year)	$0	Coinsurance (no deductible)
Home Infusion Therapy	$0	Covered in-network only
Hospice Care (Unlimited days combined IP & OP per lifetime)	$0	Covered in-network only
Physical Therapy[5] (Up to 90 visits per calendar year combined in home, office or outpatient facility)	$10 copayment	Covered in-network only
Other Short-Term Rehabilitative Therapies – Speech/Language[5], Occupational[5], Vision (Up to 30 visits per calendar year combined in home, office or outpatient facility)	$10 copayment	Covered in-network only

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Cardiac Rehabilitation	$10 copayment	Deductible and Coinsurance
Second Surgical Opinion	$10 copayment	Deductible and Coinsurance
Kidney Dialysis	$0	Deductible and Coinsurance
Inpatient Care[5]	**Member Pays In-Network**	**Member Pays Out-of-Network**
Inpatient Hospital (As many days as is medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance
Surgery, Covered Surgical Assistant, Anesthesia	$0	Deductible and Coinsurance
Physical Therapy, Physical Medicine, or Rehabilitation (Up to 90 inpatient days per calendar year)	$0	Deductible and Coinsurance
Skilled Nursing Facility (Up to 120 days per calendar year)	$0	Covered in-network only
Mental Health	**Member Pays In-Network**	
Outpatient Visits in Office	$10 copayment	Deductible and Coinsurance
Outpatient Visits in Facility	$0	Deductible and Coinsurance
Inpatient Care[8] (As many days as medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance
Alcohol/Substance Abuse	**Member Pays In-Network**	**Member Pays Out-of-Network**
Outpatient Visits in Office	$10 copayment	Deductible and Coinsurance
Outpatient Visits in Facility	$0	Deductible and Coinsurance
Inpatient Detoxification[8] (As many days as medically necessary; semiprivate room and board)	$0	Deductible and Coinsurance
Inpatient Rehabilitation[8]	$0	Deductible and Coinsurance
Other	**Member Pays In-Network**	**Member Pays Out-of-Network**
Medical Supplies	$0 when obtained through Anthem's medical supplies vendor	In-network benefits apply
Durable Medical Equipment[6]	$0	Covered in-network only
Prosthetics & Orthotics[6]	$0	Covered in-network only
Ambulance (air ambulance)	$0	In-network benefits apply
Prescription Drugs[10]		Covered in-network only
Retail Program – One copayment required for up to a 30-day supply	$0 Deductible per person per calendar year $5 copay or Tier 1 $10 copay for Tier 2 $25 copay for Tier 3 Includes Contraceptives (Retail & Mail-Order)	
Mail-Order Program[11] – Only two copayments required for a 90-day supply	$0 Deductible The Mail-Order Program has the same copayments as the Retail Program listed above.	
Routine Vision Benefits through Blue View Vision Must use the BVV -Insight Network (Every 24 months)	$5 copay for exam $115 allowance for frames, $10 copay for lenses $75 allowance for contact lenses	Up to $30 reimbursement for exams Up to $64 reimbursement for frames Up to $25 reimbursement for Single vision lenses, $35 for bifocal lenses, and $45 for trifocal lenses. Up to $75 reimbursement for Contact lenses.

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(1) Network provider delivers care.
(2) Out-of-network services (except Mental Health and Alcohol/Substance Abuse) are those from a provider that does not participate in Anthem's Blue Access network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. (This does not apply to emergency benefits.) See (8) for Mental Health and Alcohol/ Substance Abuse Services.
(3) Out-of-network (O-O-N) providers – those who do not participate in Anthem's Blue Access network, or with another Blue Cross and Blue Shield Plan through the BlueCard® PPO Program. Out-of-network providers who do not participate with Anthem or with another Blue Cross and Blue Shield Plan, may balance bill over Anthem's allowed amount.
(4) Preventive Care benefits not subject to copayment, deductible and coinsurance; when provided In-Network include; mammography screenings, cervical cancer screenings, colorectal cancer screenings, prostate cancer screenings, hypercholesterolemia screenings, diabetes screenings for pregnant women, bone density testing, annual physical examinations and annual obstetric and gynecological examinations. May also include other services as required under State and Federal Law. May be subject to age and frequency limits.
(5) You are responsible for obtaining precertification from Anthem's Medical Management Program for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained. For ambulatory surgery, precertification is required for reconstructive surgery, outpatient transplants and ophthalmological or eye-related procedures. Precertification is also required for cosmetic surgery, an excluded benefit except when medically necessary.
(6) For services received from an Anthem Blue Access provider, the provider must precertify in-network services; Anthem Blue Access providers cannot bill members beyond the copayment for covered services. Outside Anthem's network area, you must obtain precertification from Anthem's Medical Management Program for services from in-network BlueCard® PPO providers. You are responsible for obtaining precertification from Anthem's Medical Management Program for in-area and out-of-area out-of-network services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.
(7) Anthem's network provider must precertify in-network services; Anthem network providers cannot bill members beyond the co-payment for covered services. Precertification is not required for out-of-network services, nor for out-of-area in-network BlueCard® PPO provider services.
(8) You are responsible for obtaining precertification from the Behavioral Healthcare Manager for these services. Your provider may call for you, but you will be responsible for penalties applied if precertification is not obtained.
(9) Anthem's network provider must obtain authorization for clinical/medical necessity for in-network services; Anthem network providers cannot bill members beyond the in-network deductible and coinsurance for covered services. Authorization is not required for out-of-network services or for services rendered from in-network Blue Access providers outside of Anthem's network area.
(10) This prescription drug coverage meets the CMS standard for Creditable Coverage under the Medicare Modernization Act of 2003.
(11) To receive a 90-day supply of prescription drugs through Anthem's Mail-Order Program, the prescription must be written specifically for a 90-day supply.

NOTE: This is a benefits summary only and is subject to the terms, conditions, limitations and exclusions set forth in your Certificate of Coverage, Schedule of Benefits, and any additional Riders or Contracts your group has purchased. Be sure to consult your benefit Contract or Certificate for full details about your coverage. To the extent that there is a conflict between this Summary and your benefit Contract or Certificate, the terms of the Contract or Certificate will control. Failure to comply with Anthem's Medical Management or Behavioral Healthcare Management Program requirements could result in benefit reductions.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Included are preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

Prepared on 5.1.2024