Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: PEGHP/City Of Albany: Anthem Blue Choice PPO PPO5 Buy Up Plan

Your Network: BlueChoice PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	**K Health:** No charge **LiveHealth Online:** $35 copay per visit deductible does not apply
Mental Health & Substance Use Disorder Services	$35 copay per visit deductible does not apply
Specialist care	$45 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
Overall Deductible	$1,000 member / $3,000 family	$1,000 member / $3,000 family
Overall Out-of-Pocket Limit	$9,100 member / $18,200 family	$18,200 member / $36,400 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member 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 member deductible or per member out-of-pocket limit. All medical deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Out-of-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services). The In-Network and Out-of-Network deductibles are combined and accumulate toward each other. The In-Network and Out-of-Network out-of-pocket limit amounts accumulate toward each other.		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$35 copay per visit deductible does not apply	30% coinsurance after deductible is met
Specialist Care *virtual and office*	$45 copay per visit deductible does not apply	30% 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
Other Practitioner Visits		
Maternity Doctor services (prenatal/postnatal care and delivery)	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Retail Health Clinic Visit *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$35 copay per visit deductible does not apply	30% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 30 visits per year.*	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Prescription Drugs *Dispensed in the office*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Surgery	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met
Diagnostic Services		
Lab		
Office	No charge	30% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	30% coinsurance after deductible is met
Outpatient Hospital	No charge	30% coinsurance after deductible is met
X-Ray		
Office	No charge	30% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	20% 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 an Out-of-Network Provider
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.*	$60 copay per visit deductible does not apply	30% coinsurance after deductible is met
Emergency Room Facility Services *Your copay, coinsurance and deductible will be waived if admitted.*	$200 copay per visit and 20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance after deductible is met	Covered as In-Network
Ambulance *Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Physician and other services *including surgeon fees*		
Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Ambulatory Surgical Center	20% 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 an Out-of-Network Provider
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Physician and other services *including surgeon fees*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Home Health Care *Coverage is limited to 120 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies is limited to 50 visits combined per year. Coverage for speech therapy is limited to 50 visits per year.*		
Office	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Pulmonary rehabilitation *office and outpatient hospital*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Cardiac rehabilitation *office and outpatient hospital*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy *office and outpatient hospital*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 30 days combined per benefit period.*	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Inpatient Hospice	No charge	No charge
Durable Medical Equipment	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period.*	20% 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 an Out-of-Network Provider
Hearing Aids *Coverage is limited to 1 item per hearing-impaired ear up to $3,000 per ear, every 48 months for members through age 18.*	20% coinsurance after deductible is met	30% 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
Pharmacy Deductible	Not covered	Not covered
Pharmacy Out-of-Pocket Limit	Not covered	Not covered
Prescription Drug Coverage **Network:** **Drug List:**		
Day Supply Limits:		
Tier 1 - Typically Generic	Not covered (retail and home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand	Not covered (retail and home delivery)	Not covered (retail and home delivery)
Tier 3 - Typically Non-Preferred Brand	Not covered (retail and home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	Not covered (retail and home delivery)	Not covered (retail and home delivery)

Notes:

- 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.

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 Certificate of Coverage. If there is a difference between this summary and the Certificate of Coverage the Certificate of Coverage will prevail.

Questions: (855) 397-9267 or visit us at www.anthem.com

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(TTY/TDD: 711)

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