

# Your summary of benefits



Anthem® Blue Cross

Your Contract Code: 79R1

Your Plan: City of Albany: PPO - Firefighter Plan

Your Network: Blue Card PPO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
<b>Primary Care, and medical services for urgent/acute care</b>	<b>K Health:</b> No charge <b>LiveHealth Online:</b> \$12 copay per visit
<b>Mental Health &amp; Substance Use Disorder Services</b>	\$12 copay per visit
<b>Specialist care</b>	\$30 copay per visit

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<b>Overall Deductible</b>	\$0 person / \$0 family	\$200 person / \$500 family
<b>Overall Out-of-Pocket Limit</b>	\$4,700 person / \$9,400 family	\$1,200 person / \$3,000 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 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.

All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.

In-Network and Non-Network out-of-pocket limit amounts are separate and do not accumulate toward each other.

<b>Doctor Visits (virtual and office)</b> You are encouraged to select a Primary Care Physician (PCP).		
<b>Primary Care (PCP) and Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i>	\$15 copay per visit	20% coinsurance after deductible is met
<b>Specialist Care</b> <i>virtual and office</i>	\$30 copay per visit	20% coinsurance after deductible is met
<b>Other Practitioner Visits</b>		
<b>Routine Maternity Care</b> (Prenatal and Postnatal)	No charge	20% 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> for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.	\$15 copay per visit	20% coinsurance after deductible is met
<b>Chiropractic Services</b>	\$30 copay per visit <sup>‡</sup>	20% coinsurance after deductible is met
<b>Acupuncture</b>	\$30 copay per visit	20% coinsurance after deductible is met
<b><u>Other Services in an Office</u></b>		
<b>Allergy Testing</b>	\$30 copay per visit <sup>‡</sup>	20% coinsurance after deductible is met
<b>Prescription Drugs</b> Dispensed in the office	No charge	Not covered
<b>Surgery</b>	\$30 copay per visit <sup>‡</sup>	20% coinsurance after deductible is met
<b>Preventive care / screenings / immunizations</b>	No charge	20% coinsurance after deductible is met
<b><u>Diagnostic Services</u></b>		
<b>Lab</b>		
Office	No charge	20% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	20% coinsurance after deductible is met
Outpatient Hospital	No charge	20% coinsurance after deductible is met
<b>X-Ray</b>		
Office	No charge	20% coinsurance after deductible is met
Outpatient Hospital	No charge	20% coinsurance after deductible is met
<b>Advanced Diagnostic Imaging</b> for example: MRI, PET and CAT scans		
Office	No charge	20% coinsurance after deductible is met
Outpatient Hospital	No charge	20% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><b><u>Emergency and Urgent Care</u></b></p> <p><b>Urgent Care</b> includes doctor services. Additional charges may apply depending on the care provided.</p>	\$35 copay per visit	\$35 copay per visit after deductible is met
<p><b>Emergency Room Facility Services</b> Your copay will be waived if admitted within 24 hours.</p>	\$100 copay per occurrence for the first 1 visit	Covered as In-Network
<p><b>Emergency Room Doctor and Other Services</b></p>	No charge	Covered as In-Network
<p><b>Ambulance</b></p>	No charge	Covered as In-Network
<p><b>Outpatient Mental Health and Substance Use Disorder Services at a Facility</b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Doctor Services</p>	No charge	20% coinsurance after deductible is met
<p><b>Outpatient Surgery</b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p><b>Physician and other services including surgeon fees</b></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	No charge	20% coinsurance after deductible is met
<p><b>Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)</b></p> <p><b>Facility Fees</b> Coverage for Inpatient Rehabilitation is limited to 90 days per benefit period.</p> <p><b>Physician and other services including surgeon fees</b></p> <p><b>Home Health Care</b> Coverage is limited to 200 visits per benefit period.</p>	No charge	20% 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 physical therapy is limited to 90 visits per benefit period.</i> <i>Coverage for occupational and speech therapies is limited to 30 visits combined per benefit period.</i>		
Office	\$15 copay per visit	20% coinsurance after deductible is met
Outpatient Hospital	No charge	20% coinsurance after deductible is met
<b>Pulmonary rehabilitation</b>		
Office	\$30 copay per visit <sup>‡</sup>	20% coinsurance after deductible is met
Outpatient Hospital	No charge	20% coinsurance after deductible is met
<b>Cardiac rehabilitation</b>		
Office	\$30 copay per visit <sup>‡</sup>	20% coinsurance after deductible is met
Outpatient Hospital	No charge	20% coinsurance after deductible is met
<b>Dialysis/Hemodialysis</b> office and outpatient hospital	No charge	20% coinsurance after deductible is met
<b>Chemo/Radiation Therapy</b> office and outpatient hospital	No charge	20% coinsurance after deductible is met
<b>Skilled Nursing Care (facility)</b> <i>Coverage is limited to 365 days per benefit period.</i>	No charge	Not covered
<b>Inpatient Hospice</b>	No charge	Not covered
<b>Durable Medical Equipment</b>	No charge	Not covered
<b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	No charge	Not covered

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
<b>Pharmacy Deductible</b>	Not applicable	Not covered
<b>Pharmacy Out-of-Pocket Limit</b>	\$1,900 person/ \$3,800 family	Not covered
<b>Prescription Drug Coverage</b> <b>Network: Base Network</b> <b>Drug List: National Direct Plus</b>		
<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 CarelonRx 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.		
<b>Tier 1 - Typically Generic</b>	\$5 copay per prescription (retail) and \$10 copay per prescription (home delivery)	Not covered
<b>Tier 2 – Typically Preferred Brand</b>	\$20 copay per prescription (retail) and \$40 copay per prescription (home delivery)	Not covered
<b>Tier 3 - Typically Non-Preferred Brand/Specialty Drugs</b>	\$35 copay per prescription (retail) and \$70 copay per prescription (home delivery)	Not covered

**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.
- 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: Visit us at [www.anthem.com](http://www.anthem.com)

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## 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 (844) 235-4455

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 (844) 235-4455.

**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՝ (844) 235-4455:

**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(844) 235-4455。

**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 (844) 235-4455 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 (844) 235-4455.

**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 (844) 235-4455.

**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 (844) 235-4455.

**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、(844) 235-4455 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(844) 235-4455로 문의하십시오.

**Navajo (Diné):** Díí naaltsoos biká'ígíí ɬahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'aadoo bájáh ilníigóó. Ata' halne'ígíí ɬa' bich'í' hadeesdzih nínízingo kojí' hodíilnih (844) 235-4455.

## 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: (844) 235-4455.

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**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. (844) 235-4455.

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