

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

## Western Reserve Care Solutions

Your Plan: Anthem NonLink Blue Connection HMO

Your Network: Blue Connection

**Effective Date: 1/1/2025**

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
<b>Primary Care, and medical services for urgent/acute care</b>	No charge medical deductible does not apply
<b>Mental Health &amp; Substance Use Disorder Services</b>	No charge medical deductible does not apply
<b>Specialist care</b>	\$30 copay per visit medical 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>	\$250 person / \$500 family	Not covered
<b>Overall Out-of-Pocket Limit</b>	\$2,000 person / \$6,000 family	Not covered

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.

### **Doctor Visits (virtual and office)** *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, office and outpatient facility</i>	\$20 copay per visit medical deductible does not apply	Not covered
<b>Specialist Care</b> <i>virtual, office and outpatient facility</i>	\$30 copay per visit medical deductible does not apply	Not covered
<b><u>Other Practitioner Visits</u></b>		
<b>Maternity Doctor services</b> (prenatal/postnatal care and delivery)	0% coinsurance after medical deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Retail Health Clinic</b> for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.	\$20 copay per visit medical deductible does not apply	Not covered
<u><b>Other Services in an Office</b></u> <b>Allergy Testing</b>  <b>Prescription Drugs</b> <i>Dispensed in the office</i>  <b>Surgery</b>	0% coinsurance after medical deductible is met  0% coinsurance after medical deductible is met  0% coinsurance after medical deductible is met	Not covered  Not covered  Not covered
<b>Preventive care / screenings / immunizations</b>	No charge	Not covered
<b>Preventive Care for Chronic Conditions</b> <i>per IRS guidelines</i>	No charge	Not covered
<u><b>Diagnostic Services</b></u>  <b>Lab</b> Office  Freestanding Lab/Reference Lab  Outpatient Hospital	0% coinsurance after medical deductible is met  No charge  0% coinsurance after medical deductible is met	Not covered  Not covered  Not covered
<b>X-Ray</b>  Office  Freestanding Radiology Center  Outpatient Hospital	0% coinsurance after medical deductible is met  0% coinsurance after medical deductible is met  0% coinsurance after medical deductible is met	Not covered  Not covered  Not covered

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>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</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>\$20 copay per visit medical deductible does not apply</p> <p>\$125 copay per visit after medical deductible is met</p> <p>No charge</p> <p>\$50 copay per trip after medical deductible is met</p>	<p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><b><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></b></p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p>
<p><b><u>Outpatient Surgery</u></b></p> <p><b>Facility Fees</b></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<p><b>Physician and other services</b> <i>including surgeon fees</i></p> <p>Hospital</p> <p>Ambulatory Surgical Center</p>	<p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p>
<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>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><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></p>	<p>0% coinsurance after medical deductible is met</p>	<p>Not covered</p>
<p><b>Rehabilitation and Habilitation services</b> <i>including physical, occupational and speech therapies.</i> <i>Coverage for physical, occupational, and speech therapies is limited to 30 visits each per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p> <p><b>Manipulation Therapy</b> <i>office and outpatient hospital</i> <i>Coverage is limited to 12 visits per benefit period.</i></p>	<p>\$20 copay per visit medical deductible does not apply</p> <p>\$20 copay per visit medical deductible does not apply</p> <p>\$30 copay per visit medical deductible does not apply</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><b>Pulmonary rehabilitation</b> <i>office and outpatient hospital</i> <i>Coverage is limited to 20 visits per benefit period.</i></p>	<p>\$20 copay per visit medical deductible does not apply</p>	<p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use an Out-of-Network Provider
<b>Cardiac rehabilitation</b> <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i>	\$20 copay per visit medical deductible does not apply	Not covered
<b>Dialysis/Hemodialysis</b> <i>office and outpatient hospital</i>	0% coinsurance after medical deductible is met	Not covered
<b>Chemo/Radiation Therapy</b>  Office  Outpatient Hospital	\$30 copay per visit medical deductible does not apply <sup>‡</sup>  \$20 copay per visit medical deductible does not apply	Not covered  Not covered
<b>Skilled Nursing Care (facility)</b> <i>Coverage for Skilled Nursing is 100 days per benefit period and Inpatient Rehabilitation facility (includes services in an outpatient day rehabilitation program) is limited to 60 days per benefit period.</i>	0% coinsurance after medical deductible is met	Not covered
<b>Inpatient Hospice</b>	0% coinsurance after medical deductible is met	Not covered
<b>Durable Medical Equipment</b>	0% coinsurance after medical deductible is met	Not covered
<b>Prosthetic Devices</b> <i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period.</i>	0% coinsurance after medical deductible is met	Not covered

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 covered
<b>Pharmacy Out-of-Pocket Limit</b>	Combined with In-Network medical out-of-pocket limit	Not covered
<b>Prescription Drug Coverage</b> <b>Network: Base Network</b> <b>Drug List: National Direct Plus</b> <i>If you select a brand name drug when a generic drug is available, additional cost sharing</i>		

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use an Out-of-Network Pharmacy
<i>amounts may apply.</i>		
<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 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 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.</p>		
<b>Tier 1 - Typically Generic</b>	\$15 copay per prescription (retail) and \$30 copay per prescription (home delivery)	Not covered (retail and home delivery)
<b>Tier 2 - Typically Preferred Brand</b>	\$30 copay per prescription (retail) and \$60 copay per prescription (home delivery)	Not covered (retail and home delivery)
<b>Tier 3 - Typically Non-Preferred Brand</b>	\$30 copay per prescription (retail) and \$60 copay per prescription (home delivery)	Not covered (retail and home delivery)
<b>Tier 4 - Typically Specialty (brand and generic)</b>	\$30 copay per prescription (retail and home delivery)	Not covered (retail and home delivery)

**Notes:**

- Dependent Age Limit: to the end of the month in which the child attains age 26.
- No charge means no deductible / copayment / coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount.
- Office visits in an outpatient setting is the same as the professional setting. This is also to include the facility fee that these hospital owned physicians are able to charge.
- 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.
- 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 Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.*

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Questions: (833) 639-1634 or visit us at [www.anthem.com](http://www.anthem.com)

# Your summary of benefits



Your Plan: **Anthem NonLink Blue Connection HMO \$250**

Your Network: Blue Connection

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



## 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) 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。

**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) 639-1634 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 (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.

**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) 639-1634 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) 639-1634로 문의하십시오.

**Navajo (Diné):** Díí naaltsoos biká'ígíí lahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehj bee nił hodoonih t'áadoo báąh ilínígóó. Ata' halne'ígíí ła' bich'í' hadeesdzih ninízingo kojì' hodiłlnih (833) 639-1634.

## 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) 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.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (833) 639-1634.

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (833) 639-1634.

### 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>.