# Your summary of benefits

ASO

Anthem® Blue Cross and Blue Shield

Your Plan: Forklifts of St Louis Inc: Anthem Blue Access Choice PPO

Your Network: Blue Access Choice

| Visits with Virtual Care-Only Providers | Cost through our mobile app and website |
|---|---|
| **Primary Care, and medical services for urgent/acute care** | No charge medical deductible does not apply |
| **Mental Health & Substance Use Disorder Services** | No charge medical deductible does not apply |
| **Specialist care** | $40 copay per visit medical deductible does not apply |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Overall Deductible** | $500 person / $1,500 family | $1,500 person / $4,500 family |
| **Overall Out-of-Pocket Limit** | $2,000 person / $3,500 family | $12,000 person / $24,000 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.<br>All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit (excluding Non-Network Human Organ and Tissue Transplant (HOTT), Cellular and Gene Therapy services).<br>In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other. | | |
| **Doctor Visits (virtual and office)** *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.* | | |
| **Primary Care (PCP) and Mental Health and Substance Use Disorder Services** *virtual and office* | $20 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |
| **Specialist Care** *virtual and office* | $40 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Other Practitioner Visits** | | |
| **Routine Maternity Care** (Prenatal and Postnatal) | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Retail Health Clinic** *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 | 50% coinsurance after medical deductible is met |
| **Chiropractic Services**<br>*Coverage is limited to 26 visits per benefit period.* | 50% coinsurance medical deductible does not apply | Not covered |
| **Other Services in an Office** | | |
| **Allergy Testing**<br>*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.* | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Prescription Drugs** *Dispensed in the office* | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Surgery** | $40 copay per visit medical deductible does not apply‡ | 50% coinsurance after medical deductible is met |
| **Preventive care / screenings / immunizations** | No charge | 50% coinsurance after medical deductible is met |
| **Preventive Care for Chronic Conditions** *per IRS guidelines* | No charge | 50% coinsurance after medical deductible is met |
| **Diagnostic Services**<br>**Lab** | | |
| Office | No charge | 50% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **X-Ray** | | |
| Office | No charge | 50% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Advanced Diagnostic Imaging** *for example: MRI, PET and CAT scans* | | |
| Office | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| Freestanding Radiology Center | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Emergency and Urgent Care** | | |
| **Urgent Care** *includes doctor services. Additional charges may apply depending on the care provided.* | $75 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |
| **Emergency Room Facility Services** *Your copay will be waived if admitted.* | $200 copay per visit after medical deductible is met | Covered as In-Network |
| **Emergency Room Doctor and Other Services** | 20% coinsurance after medical deductible is met | Covered as In-Network |
| **Ambulance** *Authorized Non-Network non-emergency ambulance services are limited to an Anthem maximum payment of $50,000 per trip.* | 20% coinsurance after medical deductible is met | Covered as In-Network |
| **Outpatient Mental Health and Substance Use Disorder Services at a Facility** | | |
| Facility Fees | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| Doctor Services | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Outpatient Surgery** | | |
| **Facility Fees** | | |
| Hospital | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| Ambulatory Surgical Center | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Physician and other services** *including surgeon fees* | | |
| Hospital | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| Ambulatory Surgical Center | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)** | | |
| **Facility Fees** | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Human Organ and Tissue Transplants**<br>*Cornea transplants are treated the same as any other illness and subject to the medical benefits.* | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Physician and other services** *including surgeon fees* | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Home Health Care**<br>*Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.* | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Rehabilitation and Habilitation services** *including physical, occupational and speech therapies.*<br>*Coverage for physical and occupational therapies is limited to 40 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.* | | |
| Office | $20 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Pulmonary rehabilitation** | | |
| Office | $40 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Cardiac rehabilitation**<br>*Coverage is limited to 36 visits per benefit period.* | | |
| Office | $40 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Dialysis/Hemodialysis** | | |
| Office | $40 copay per visit medical deductible does not apply | 50% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Chemo/Radiation Therapy** | | |
| Office | $40 copay per visit medical deductible does not apply‡ | 50% coinsurance after medical deductible is met |
| Outpatient Hospital | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |

| Covered Medical Benefits | Cost if you use an In-Network Provider | Cost if you use a Non-Network Provider |
|---|---|---|
| **Skilled Nursing Care (facility)**<br>*Coverage for Skilled Nursing, Outpatient Rehabilitation and Inpatient Rehabilitation facility settings is limited to 150 days combined per benefit period.* | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Inpatient Hospice** | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Durable Medical Equipment** | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Prosthetic Devices**<br>*Coverage for wigs is limited to 1 item after cancer treatment per benefit period.* | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |
| **Hearing Aids**<br>*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.* | 20% coinsurance after medical deductible is met | 50% coinsurance after medical deductible is met |

| Covered Prescription Drug Benefits | Cost if you use an In-Network Pharmacy | Cost if you use a Non-Network Pharmacy |
|---|---|---|
| **Pharmacy Deductible** *In-Network is separate from Non-Network Pharmacies* | Not applicable | Not applicable |
| **Pharmacy Out-of-Pocket Limit** | Combined with In-Network medical out-of-pocket limit | Combined with Non-Network medical out-of-pocket limit |
| **Prescription Drug Coverage**<br>**Network:** ***Base Network***<br>**Drug List:** ***National*** *If you select a brand name drug when a generic drug is available, additional cost sharing amounts may apply.* | | |
| **Day Supply Limits:**<br>**Retail Pharmacy** *30 day supply (cost shares noted below)*<br>**Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies noted below applies).*<br>**Home Delivery Pharmacy** *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.*<br>**Specialty Pharmacy** *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.* | | |

| Covered Prescription Drug Benefits | Cost if you use an In-Network Pharmacy | Cost if you use a Non-Network Pharmacy |
|---|---|---|
| **Tier 1 - Typically Generic** | $10 copay per prescription (retail and home delivery) | 50% coinsurance (retail) and Not covered (home delivery) |
| **Tier 2 – Typically Preferred Brand** | $25 copay per prescription (retail) and $65 copay per prescription (home delivery) | 50% coinsurance (retail) and Not covered (home delivery) |
| **Tier 3 - Typically Non-Preferred Brand** | $45 copay per prescription (retail) and $135 copay per prescription (home delivery) | 50% coinsurance (retail) and Not covered (home delivery) |
| **Tier 4 - Typically Specialty (brand and generic)** | 25% coinsurance up to $350 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 a Non-Network Provider |
|---|---|---|
| *This is a brief outline of your vision coverage. To receive the In-Network benefit, you must use a Blue View Vision Provider. Only children's vision services count towards your out-of-pocket limit.* | | |
| **Children's Vision exam (up to age 19)**<br>*Limited to 1 exam per benefit period.* | No charge | $0 copayment up to plan's Maximum Allowed Amount |
| **Adult Vision exam (age 19 and older)**<br>*Limited to 1 exam per benefit period.* | No charge | Reimbursed Up to $42 |

**Notes:**

- Dependent Age Limit: to the end of the month in which the child attains age 26.
- Members are encouraged to always obtain prior approval when using Non-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 a Non-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

# Your summary of benefits

Anthem

## Your Plan: Forklifts of St Louis Inc: Anthem Blue Access Choice PPO

## Your Network: Blue Access Choice

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) 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** (فارسي): 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.

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**Navajo (Diné):** Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (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.

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**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) 578-4436.

**It's important we treat you fairly**

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