

# Your summary of benefits



Anthem® Blue Cross and Blue Shield

Your 2026 Contract Code: 957K

Your Plan: Anthem Convenient Care Silver Guided Access HMO 3500/7000 w/HSA

Your Network: HMO

*This summary of benefits is a brief outline of coverage, designed to help you with the selection process. Unless stated otherwise, services received in an office, Ambulatory Surgical Center, or outpatient facility are combined across all outpatient settings. 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 Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.*

| 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                                    |
| <b>Mental Health &amp; Substance Use Disorder Services</b>      | No charge                                    |
| <b>Specialist care</b>                                          | \$75 copay per visit after deductible is met |

| Covered Medical Benefits                                                                                                                                                                                                                                                                                                                                                                                               | Cost if you use an In-Network Provider                                             | Cost if you use an Out-of-Network Provider |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------|
| <b>Overall Deductible</b>                                                                                                                                                                                                                                                                                                                                                                                              | \$3,500 person /<br>\$7,000 family                                                 | Not covered                                |
| <b>Overall Out-of-Pocket Limit</b><br><i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period.</i>                                                                                                                                                                                                                                           | \$7,000 person /<br>\$14,000 family                                                | Not covered                                |
| <i>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.</i> |                                                                                    |                                            |
| <i>All medical services subject to a coinsurance are also subject to the annual medical deductible.</i>                                                                                                                                                                                                                                                                                                                |                                                                                    |                                            |
| <i>Your copays, coinsurance and deductible count toward your out-of-pocket limit. However, member cost sharing for the following service(s) do not apply toward the out-of-pocket limit: adult vision.</i>                                                                                                                                                                                                             |                                                                                    |                                            |
| <b>Doctor Visits (virtual and office)</b> <i>Your plan requires the selection of a Primary Care Physician (PCP). A referral from your Primary Care Physician (PCP) is required for Specialist care and most other providers for select covered services.</i>                                                                                                                                                           |                                                                                    |                                            |
| <b>Preferred PCP</b> <i>virtual and office</i>                                                                                                                                                                                                                                                                                                                                                                         | <b>virtual</b> -No charge after deductible is met<br><b>office</b> -\$10 copay per | Not covered                                |

| Covered Medical Benefits                                                                                                                                                                                                                                                                                                             | Cost if you use an In-Network Provider                                                                                                                                        | Cost if you use an Out-of-Network Provider                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| <b>Primary Care (PCP)</b> <i>virtual and office</i><br><br><b>Mental Health and Substance Use Disorder Services</b> <i>virtual and office</i><br><br><b>Specialist Provider</b> <i>virtual and office</i>                                                                                                                            | visit after deductible is met<br>\$50 copay per visit after deductible is met<br>\$50 copay per visit after deductible is met<br>\$75 copay per visit after deductible is met | Not covered<br><br>Not covered<br><br>Not covered                    |
| <b>Other Practitioner Visits</b><br>Maternity Doctor services (prenatal/postpartum care and delivery)<br><i>In-Network preventive prenatal and postpartum services are covered at 100%.</i><br><br>Retail Health Clinic<br><br>Spinal Manipulation<br><i>Coverage is limited to 50 visits per benefit period.</i><br><br>Acupuncture | \$500 copay per pregnancy after deductible is met<br>\$50 copay per visit after deductible is met<br>\$50 copay per visit after deductible is met<br>Not covered              | Not covered<br><br>Not covered<br><br>Not covered<br><br>Not covered |
| <b>Other Services in an Office</b><br>Allergy Testing<br><br>Prescription Drugs - Dispensed in the office<br><i>For the drugs itself dispensed in the office through infusion/injection.</i><br><br>Surgery                                                                                                                          | \$75 copay per visit after deductible is met <sup>‡</sup><br>\$500 copay per visit after deductible is met<br>\$75 copay per visit after deductible is met <sup>‡</sup>       | Not covered<br><br>Not covered<br><br>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                                                          |
| <b><u>Diagnostic Services Lab</u></b><br>Office<br><br>Freestanding Lab/Reference Lab                                                                                                                                                                                                                                                | \$75 copay per visit after deductible is met <sup>‡</sup><br>No charge after deductible is met                                                                                | Not covered<br><br>Not covered                                       |

| Covered Medical Benefits                                                                                                                                                                                                           | Cost if you use an In-Network Provider                    | Cost if you use an Out-of-Network Provider |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------|
| Outpatient Hospital                                                                                                                                                                                                                | \$75 copay per visit after deductible is met              | Not covered                                |
| <b><u>Diagnostic Services X-Ray</u></b>                                                                                                                                                                                            |                                                           |                                            |
| Office                                                                                                                                                                                                                             | \$75 copay per visit after deductible is met <sup>‡</sup> | Not covered                                |
| Freestanding Radiology Center                                                                                                                                                                                                      | \$60 copay per visit after deductible is met              | Not covered                                |
| Outpatient Hospital                                                                                                                                                                                                                | \$75 copay per visit after deductible is met              | Not covered                                |
| <b><u>Diagnostic Services Advanced Diagnostic Imaging</u></b> - for example: MRI, PET and CAT scans                                                                                                                                |                                                           |                                            |
| Office                                                                                                                                                                                                                             | \$250 copay per visit after deductible is met             | Not covered                                |
| Freestanding Radiology Center                                                                                                                                                                                                      | \$250 copay per day after deductible is met               | Not covered                                |
| Outpatient Hospital                                                                                                                                                                                                                | \$500 copay per day after deductible is met               | Not covered                                |
| <b><u>Emergency and Urgent Care</u></b>                                                                                                                                                                                            |                                                           |                                            |
| <b>Urgent Care (Office Setting)</b>                                                                                                                                                                                                | \$50 copay per visit after deductible is met              | Covered as In-Network                      |
| <b>Emergency Room Facility Services</b><br><i>Your copay will be waived if admitted.</i>                                                                                                                                           | \$1,000 copay per visit after deductible is met           | Covered as In-Network                      |
| <b>Emergency Room Doctor and Other Services</b>                                                                                                                                                                                    | No charge after deductible is met                         | Covered as In-Network                      |
| <b>Ambulance (Air and Ground)</b><br><i>Authorized Out-of-Network non-emergency ambulance services are limited to an Anthem maximum payment of \$50,000 per trip. The \$50,000 limit does not apply to air ambulance services.</i> | \$1,000 copay per trip after deductible is met            | Covered as In-Network                      |
| <b><u>Outpatient Mental Health and Substance Use Disorder Services at a Facility</u></b>                                                                                                                                           |                                                           |                                            |
| <b>Facility Fees</b>                                                                                                                                                                                                               | \$500 copay per visit after 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>Doctor Services</b>                                                                                                                                                                                                                                                                           | No charge after deductible is met                 | Not covered                                |
| <b><u>Outpatient Surgery</u></b>                                                                                                                                                                                                                                                                 |                                                   |                                            |
| <b>Facility Fees</b>                                                                                                                                                                                                                                                                             |                                                   |                                            |
| Hospital                                                                                                                                                                                                                                                                                         | \$500 copay per visit after deductible is met     | Not covered                                |
| Ambulatory Surgical Center                                                                                                                                                                                                                                                                       | \$350 copay per visit after deductible is met     | Not covered                                |
| <b>Physician and other services including surgeon fees</b>                                                                                                                                                                                                                                       |                                                   |                                            |
| Hospital                                                                                                                                                                                                                                                                                         | No charge after deductible is met                 | Not covered                                |
| Ambulatory Surgical Center                                                                                                                                                                                                                                                                       | No charge after deductible is met                 | Not covered                                |
| <b><u>Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Use Disorder Services)</u></b><br><i>If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.</i> |                                                   |                                            |
| <b>Facility fees (for example, room &amp; board)</b><br><i>Coverage for Inpatient Rehabilitation is limited to 120 days per benefit period.</i>                                                                                                                                                  | \$750 copay per admission after deductible is met | Not covered                                |
| <b>Physician and other services including surgeon fees</b>                                                                                                                                                                                                                                       | No charge after deductible is met                 | Not covered                                |
| <b><u>Home Health Care</u></b>                                                                                                                                                                                                                                                                   | \$75 copay per visit after deductible is met      | Not covered                                |
| <b><u>Therapy Services</u></b>                                                                                                                                                                                                                                                                   |                                                   |                                            |
| <b>Rehabilitation services (for example, physical/speech/occupational therapy)</b><br><i>Coverage for physical therapy, occupational therapy and speech therapy is limited to 120 visits combined per benefit period.</i>                                                                        |                                                   |                                            |
| Office                                                                                                                                                                                                                                                                                           | \$75 copay per visit after deductible is met      | Not covered                                |
| Outpatient Hospital                                                                                                                                                                                                                                                                              | \$75 copay per visit after deductible is met      | Not covered                                |
| <b>Habilitation services (for example, physical/speech/occupational therapy)</b><br><i>Coverage for physical therapy, occupational therapy and speech therapy is limited to 120 visits combined per benefit period.</i>                                                                          |                                                   |                                            |

| Covered Medical Benefits                                                                                                                                                                                    | Cost if you use an In-Network Provider            | Cost if you use an Out-of-Network Provider |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--------------------------------------------|
| Office                                                                                                                                                                                                      | \$75 copay per visit after deductible is met      | Not covered                                |
| Outpatient Hospital                                                                                                                                                                                         | \$75 copay per visit after deductible is met      | Not covered                                |
| <b>Pulmonary rehabilitation</b> office and outpatient hospital                                                                                                                                              | \$75 copay per visit after deductible is met      | Not covered                                |
| <b>Cardiac rehabilitation</b> office and outpatient hospital                                                                                                                                                | \$75 copay per visit after deductible is met      | Not covered                                |
| <b>Dialysis/Hemodialysis</b>                                                                                                                                                                                |                                                   |                                            |
| Office                                                                                                                                                                                                      | \$75 copay per visit after deductible is met      | Not covered                                |
| Outpatient Hospital                                                                                                                                                                                         | \$500 copay per visit after deductible is met     | Not covered                                |
| <b>Chemo/Radiation Therapy</b>                                                                                                                                                                              |                                                   |                                            |
| Office                                                                                                                                                                                                      | \$75 copay per visit after deductible is met      | Not covered                                |
| Outpatient Hospital                                                                                                                                                                                         | \$500 copay per visit after deductible is met     | Not covered                                |
| <b>Skilled Nursing Care (in a facility)</b><br><i>Coverage is limited to 150 days per benefit period. Limit is combined across a skilled nursing facility and an outpatient day rehabilitation program.</i> | \$750 copay per admission after deductible is met | Not covered                                |
| <b>Inpatient Hospice</b>                                                                                                                                                                                    | \$750 copay per admission after deductible is met | Not covered                                |
| <b>Durable Medical Equipment</b>                                                                                                                                                                            | \$300 copay per visit after deductible is met     | Not covered                                |
| <b>Prosthetic Devices</b><br><i>Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Coverage for hearing aids and services is limited to 1 item per ear every 3 years.</i>    | \$500 copay per visit after deductible is met     | Not covered                                |

| Covered Prescription Drug Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Cost if you use a Preferred Network Pharmacy                                                                                          | Cost if you use an In-Network Pharmacy                             | Cost if you use an Out-of-Network Pharmacy |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------|
| <b>Pharmacy Deductible</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Combined with In-Network medical deductible                                                                                           | Combined with In-Network medical deductible                        | Not covered                                |
| <b>Pharmacy Out-of-Pocket Limit</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Combined with In-Network medical out-of-pocket limit                                                                                  | Combined with In-Network medical out-of-pocket limit               | Not covered                                |
| <b>Prescription Drug Coverage</b><br><b>Network: Rx Choice Tiered Network</b><br><b>Drug List: Select</b> <i>Drugs not included on the Select drug list will not be covered. Prescription Drugs that we are required to cover by federal law under the "Preventive Care" benefit will be covered with no deductible, copayments or coinsurance when you use an In-Network Pharmacy.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                       |                                                                    |                                            |
| <b>Day Supply Limits:</b><br><b>Retail Pharmacy</b> <i>30 day supply (cost shares noted below)</i><br><b>Retail 90 Pharmacy</b> <i>90 day supply (cost shares noted below)</i><br><b>Home Delivery Pharmacy</b> <i>90 day supply (maximum cost shares noted below). Maintenance medications are available through our home delivery pharmacy. You may get two 30-day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must call us on the number on your ID card and tell us if you would like to keep getting your maintenance medications from a retail pharmacy or if you would like to use home delivery. If you do not contact us, you will pay the full retail cost of any maintenance medication until you inform us of your decision.</i><br><b>Specialty Pharmacy</b> <i>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.</i> |                                                                                                                                       |                                                                    |                                            |
| <b>Preventive Drugs</b><br><i>The deductible does not apply to prescription drugs on the PreventiveRx Plus drug list when you use a Preferred Network or an In-Network Pharmacy.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                       |                                                                    |                                            |
| <b>Tier 1 - Typically Generic</b><br><i>Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | \$10 copay per prescription after deductible is met (retail) and \$25 copay per prescription after deductible is met (home delivery)  | \$20 copay per prescription after deductible is met (retail only)  | Not covered (retail and home delivery)     |
| <b>Tier 2 - Typically Preferred Brand</b><br><i>Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | \$60 copay per prescription after deductible is met (retail) and \$150 copay per prescription after deductible is met (home delivery) | \$70 copay per prescription after deductible is met (retail only)  | Not covered (retail and home delivery)     |
| <b>Tier 3 - Typically Non-Preferred Brand</b><br><i>Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | \$125 copay per prescription after deductible is met (retail) and \$313 copay per prescription after                                  | \$145 copay per prescription after deductible is met (retail only) | Not covered (retail and home delivery)     |

| Covered Prescription Drug Benefits                      | Cost if you use a Preferred Network Pharmacy                                    | Cost if you use an In-Network Pharmacy                             | Cost if you use an Out-of-Network Pharmacy |
|---------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------|
|                                                         | deductible is met (home delivery)                                               |                                                                    |                                            |
| <b>Tier 4 - Typically Specialty (brand and generic)</b> | \$500 copay per prescription after deductible is met (retail and home delivery) | \$600 copay per prescription after deductible is met (retail only) | Not covered (retail and home delivery)     |

| Covered Vision Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Cost if you use an In-Network Provider | Cost if you use an Out-of-Network Provider |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|--------------------------------------------|
| <p><i>This is a brief outline of your vision coverage. Not all cost shares for covered services are shown below. Benefits include coverage for member's choice of eyeglass lenses or contact lenses, but not both. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/ Disclosure form/ Certificate. If there is a difference between this summary and either Evidence of Coverage/ Disclosure form/ Certificate, the Evidence of Coverage/ Disclosure form/ Certificate will prevail. Only children's vision services count towards your out-of-pocket limit.</i></p> |                                        |                                            |
| <b>Children's Vision Essential Health Benefits (up to age 19)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                        |                                            |
| <b>Child Vision Deductible</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Not applicable                         | Not applicable                             |
| <b>Vision Exam</b><br><i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | No charge                              | Not covered                                |
| <b>Frames</b><br><i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | No charge                              | Not covered                                |
| <b>Single Vision Lenses</b><br><i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | No charge                              | Not covered                                |
| <b>Bifocal Vision Lenses</b><br><i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | No charge                              | Not covered                                |
| <b>Trifocal Vision Lenses</b><br><i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | No charge                              | Not covered                                |
| <b>Elective Contact Lenses</b><br><i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | No charge                              | Not covered                                |
| <b>Non-Elective Contact Lenses</b><br><i>Coverage for In-Network Providers is limited to 1 unit per benefit period.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | No charge                              | Not covered                                |
| <b>Adult Vision (age 19 and older)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                        |                                            |
| <b>Adult Vision Deductible</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Not applicable                         | Not applicable                             |
| <b>Vision Exam</b><br><i>Coverage for In-Network Providers is limited to 1 exam per benefit period.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | \$20 copay                             | Not covered                                |
| <b>Frames</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Not covered                            | Not covered                                |
| <b>Single Vision Lenses</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Not covered                            | Not covered                                |
| <b>Bifocal Vision Lenses</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Not covered                            | Not covered                                |
| <b>Trifocal Vision Lenses</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Not covered                            | Not covered                                |
| <b>Elective Contact Lenses</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Not covered                            | Not covered                                |
| <b>Non-Elective Contact Lenses</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Not covered                            | Not covered                                |



| Covered Dental Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Cost if you use an In-Network Provider  | Cost if you use an Out-of-Network Provider |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------------|
| <p><i>This is a brief outline of your dental coverage. Not all cost shares for covered services are shown below. For a full list, including benefits, exclusions and limitations, see the combined Evidence of Coverage/ Disclosure form/ Certificate. If there is a difference between this summary and either Evidence of Coverage/ Disclosure form/ Certificate, the Evidence of Coverage/ Disclosure form/ Certificate will prevail. Only children's dental services count towards your out-of-pocket limit.</i></p> |                                         |                                            |
| <b>Children's Dental Essential Health Benefits</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         |                                            |
| <b>Diagnostic and preventive</b><br><i>Coverage for In-Network Providers is limited to 2 visits per 12 months.</i>                                                                                                                                                                                                                                                                                                                                                                                                       | No charge                               | Not covered                                |
| <b>Basic services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 40% coinsurance after deductible is met | Not covered                                |
| <b>Major services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 50% coinsurance after deductible is met | Not covered                                |
| <b>Medically Necessary Orthodontia services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 50% coinsurance after deductible is met | Not covered                                |
| <b>Cosmetic Orthodontia services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Not covered                             | Not covered                                |
| <b>Deductible</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Combined with medical deductible        | Not covered                                |
| <b>Adult Dental</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                         |                                            |
| <b>Diagnostic and preventive</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Not covered                             | Not covered                                |
| <b>Basic services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Not covered                             | Not covered                                |
| <b>Major services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Not covered                             | Not covered                                |
| <b>Deductible</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Not covered                             | Not covered                                |
| <b>Annual maximum</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Not covered                             | Not covered                                |

## Healthy Support & Rewards

To see your rewards and additional information log into the Anthem website at [anthem.com](https://www.anthem.com) or call the customer service number on your member ID card.

| Program Name                                                                  | Program Description                                                                                                                                     | Program Incentive               |
|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|
| <b>Smart Rewards<br/>(Wellbeing Solutions<br/>Engagement Package<br/>200)</b> | Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim. | Up to \$200 per member per year |

**Notes:**

- Benefit period refers to calendar year.
- For additional information on this plan, please visit [www.sbc.anthem.com](http://www.sbc.anthem.com) to obtain a “Summary of Benefits and Coverage”.
- When you receive services from an Out-of-Network Provider and your plan includes Out-of-Network benefits, you may be required to pay (i) the difference between any amount the plan pays and the provider charges for services (balance billing) in addition to (ii) any applicable copayments, co-insurance, and/or deductibles. This does not apply when you receive emergency services or as otherwise required by law; in such cases, you will only be responsible for any applicable copayments, co-insurance, and/or deductibles.
- To get benefits under this Plan, you must get Covered Services from an In-Network Provider. Services from an Out-of-Network Provider are not covered, except for Emergency Care or Authorized Services. Please have your provider contact us if you are not sure if the Out-of-Network care has been approved as an Authorized Service. Please review the “Evidence of Coverage (EOC)” for more 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 your PCP or Specialist office visit copay for certain services provided in their office.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, 3D mammography, breast ultrasounds and MRIs are covered in full after deductible as required by state mandate.
- This health plan includes an Employee Assistance Program (EAP) to support your emotional health and wellness with work life resources, including one-on-one counseling by phone, in person and online. Three counseling visits are available at no charge to a member. EAP member service is accessible 24/7/365.

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Questions: (855) 330-1218 or visit us at [www.anthem.com](http://www.anthem.com)

NV/SG/Anthem Convenient Care Silver Guided Access HMO 3500/7000 w/HSA/957K/2026

## We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

### Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

### Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

### Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

### Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인인가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

### Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

### Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

### French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòm nan dokiman sa a.

### Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجاناً. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضاً طلب تنسيقات أخرى لهذه الوثيقة.

### French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

### Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

### Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Դարգապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

### Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください。視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

### Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

### German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

### Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

### Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

### TTY/TTD:711

### It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>