Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your 2022 Contract Code: 6BC5

Your Plan: Anthem Silver Choice PPO 3000/30%/8700

Your Network: Choice PPO

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.

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$3,000 person / $6,000 family	$5,500 person / $11,000 family	$11,000 person / $22,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$8,700 person / $17,400 family	$8,700 person / $17,400 family	$17,400 person / $34,800 family
Preventive care/screening/immunization *Preferred Network and In-Network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	No charge	50% coinsurance after deductible is met
Virtual Care (Telemedicine / Telehealth Visits)			

Your summary of benefits

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Virtual Visits with Doctors who also provide services in person			
Primary Care (PCP)	$25 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Mental Health and Substance Abuse care	$25 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist	$50 copay per visit deductible does not apply	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Medical Chats and Virtual (Video) Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups*	No charge		
Virtual Visits from Online Provider LiveHealth Online - *via www.livehealthonline.com; our mobile app, website or Anthem-enabled device*			
Primary Care (PCP) and Mental Health and Substance Abuse	No charge for the first 12 visits and then $10 copay per visit deductible does not apply		
Specialist Care	$50 copay per visit deductible does not apply		
Visits in an Office			
Primary Care (PCP)	$25 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care	$50 copay per visit deductible does not apply	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use a Preferred Network Provider	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) *Preferred Network and In-Network preventive prenatal and postnatal services are covered at 100%.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic	$25 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Spinal Manipulation *Coverage is limited to 50 visits per benefit period. Limit is combined Preferred Network, In-Network and Non-Network across all settings.*	$25 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Acupuncture	Not covered	Not covered	Not covered
Other Services in an Office			
Allergy Testing	$25 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Chemo/Radiation Therapy	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	$50 copay per surgery deductible does not apply	$80 copay per surgery deductible does not apply	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services			
Lab			
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	No charge	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray			
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	$250 copay per visit deductible does not apply	$250 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans			
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance after deductible is met	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care			
Urgent Care (Office Setting)	$50 copay per visit deductible does not apply	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Emergency Room copay is waived if directly admitted to the hospital.*	$1,000 copay per visit and 30% coinsurance deductible does not apply	$1,000 copay per visit and 30% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	30% coinsurance after deductible is met	30% coinsurance after deductible is met	Covered as In-Network
Emergency Room Mental Health and Substance Abuse Doctor Services	30% coinsurance deductible does not apply	30% coinsurance deductible does not apply	Covered as In-Network
Ambulance (Air and Ground) *Non-emergency, Non-Network ambulance services are limited to an Anthem maximum payment of $50,000 per trip.*	30% coinsurance after deductible is met	30% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse			
Doctor Office Visit	$25 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Facility visit			
Facility Fees	0% coinsurance deductible does not apply	0% coinsurance deductible does not apply	50% coinsurance after deductible is met
Doctor Services	0% coinsurance deductible does not apply	0% coinsurance deductible does not apply	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery			
Facility Fees			
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	$300 copay per visit deductible does not apply	$300 copay per visit deductible does not apply	50% coinsurance after deductible is met
Doctor and Other Services			
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	No charge	No charge	50% coinsurance after deductible is met
Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Abuse)			
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period. Limit is combined Preferred Network, In-Network and Non-Network.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and other services	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Recovery & Rehabilitation			
Home Health Care	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy)			

Your summary of benefits

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Coverage for physical therapy, occupational therapy and speech therapy is limited to 120 visits combined per benefit period. Limit is combined Preferred Network, In-Network and Non-Network across all settings.			
Office	$25 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy)			
Coverage for physical therapy, occupational therapy and speech therapy is limited to 120 visits combined per benefit period. Limit is combined Preferred Network, In-Network and Non-Network across all settings.			
Office	$25 copay per visit deductible does not apply	$50 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation			
Office	$50 copay per visit deductible does not apply	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation			

Your summary of benefits

Covered Medical Benefits	Cost if you use a Preferred Network Provider	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	$50 copay per visit deductible does not apply	$80 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 150 days per benefit period. Limit is combined Preferred Network, In-Network and Non-Network. Limit is combined across a skilled nursing facility and an outpatient day rehabilitation program.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	0% coinsurance after deductible is met	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per benefit period. Limit is combined Preferred Network, In-Network and Non-Network. Coverage for hearing aids services is limited to 1 item per ear every 3 years. Limit is combined Preferred Network, In-Network and Non-Network across all settings.*	50% coinsurance after deductible is met	50% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible **Additional deductible**: *Applies to Tier 2 , Tier 3 and Tier 4 Prescription Drugs for In-Network and Non-Network Providers combined.*	$500 person / $1,000 family	$500 person / $1,000 family
Pharmacy Out of Pocket	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage *Cost shares for drugs included on the Select drug list appear below. Drugs not included on the Select drug list will not be covered. Your plan uses the Advantage Network. You may receive up to a 90 day supply of medication at Retail 90 pharmacies.*		
Home Delivery Pharmacy *Maintenance medication are available through IngenioRx Home Delivery Pharmacy. You will need to call us on the number on your ID card to sign up when you first use the service.*		
Tier 1a - Typically Lower Cost Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$10 copay per prescription, Pharmacy deductible does not apply (retail) and $25 copay per prescription, Pharmacy deductible does not apply (home delivery)	50% coinsurance, Pharmacy deductible does not apply (retail) and Not covered (home delivery)
Tier 1b - Typically Generic *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$20 copay per prescription, Pharmacy deductible does not apply (retail) and $50 copay per prescription, Pharmacy	50% coinsurance, Pharmacy deductible does not apply (retail) and Not covered (home delivery)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	deductible does not apply (home delivery)	
Tier 2 – Typically Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$40 copay per prescription after Pharmacy deductible is met (retail) and $120 copay per prescription after Pharmacy deductible is met (home delivery)	50% coinsurance after Pharmacy deductible is met (retail) and Not covered (home delivery)
Tier 3 - Typically Non-Preferred Brand *Per 30 day supply (retail pharmacy and Retail 90 pharmacy). Per 90 day supply (home delivery).*	$80 copay per prescription after Pharmacy deductible is met (retail) and $240 copay per prescription after Pharmacy deductible is met (home delivery)	50% coinsurance after Pharmacy deductible is met (retail) and Not covered (home delivery)
Tier 4 - Typically Specialty (brand and generic) *Per 30 day supply (specialty pharmacy).*	25% coinsurance up to $500 per prescription after Pharmacy deductible is met (retail and home delivery)	50% coinsurance after Pharmacy deductible is met (retail) and Not covered (home delivery)

Your summary of benefits

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. 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.*		
Children's Vision Essential Health Benefits (up to age 19)		
Child Vision Deductible	Not Applicable	Not Applicable
Vision exam *Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Frames *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Single Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Bifocal Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Trifocal Vision Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Elective contact lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Non-Elective Contact Lenses *Coverage for In-Network Providers and Non-Network Providers is limited to 1 unit per benefit period.*	No charge	$0 copayment up to plan's Maximum Allowed Amount
Adult Vision (age 19 and older)		
Adult Vision Deductible	Not Applicable	Not Applicable
Vision exam	$20 copay	Reimbursed Up to $30

Your summary of benefits

Covered Vision Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Coverage for In-Network Providers and Non-Network Providers is limited to 1 exam per benefit period.		
Frames	Not covered	Not covered
Single Vision Lenses	Not covered	Not covered
Bifocal Vision Lenses	Not covered	Not covered
Trifocal Vision Lenses	Not covered	Not covered
Elective contact lenses	Not covered	Not covered
Non-Elective Contact Lenses	Not covered	Not covered

Your summary of benefits

Covered Dental Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
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.*		
Children's Dental Essential Health Benefits **Diagnostic and preventive** *Coverage for In-Network Providers and Non-Network Providers is limited to 2 visits per 12 months.*	No charge	30% coinsurance deductible does not apply
Basic services	40% coinsurance after deductible is met	50% coinsurance after deductible is met
Major services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Medically Necessary Orthodontia services	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Cosmetic Orthodontia services	Not covered	Not covered
Deductible	Combined with medical deductible	Combined with medical deductible
Adult Dental		
Diagnostic and preventive	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered
Annual maximum	Not covered	Not covered

Your summary of benefits

Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- You are encouraged to select a Primary Care Physician (PCP). Choosing a PCP is an important decision. Call us at the number on your ID card and we'll help you pick a doctor.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- If services are rendered by a non-participating provider and your plan includes out of network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating provider's charge.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- If your plan includes out-of-network coverage, covered out-of-network Human Organ and Tissue Transplant services do not apply toward the out-of-pocket limit.
- If your plan includes out of network benefits and you use a non-participating provider, you are responsible for any difference between the covered expense and the actual non-participating provider's charge. Except for out-of-network emergency services from a professional or facility inside Nevada, when receiving care from providers out-of-network, members may be subject to balance billing in addition to any applicable copayments, coinsurance and/or deductible. This amount does not apply to the out-of-network out-of-pocket limit.
- Vision services are not subject to the annual deductible.
- Emergency Care you receive from an Out-of-Network Provider will be covered as an In-Network service. But, you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible.
- Benefit period refers to calendar year.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- All covered services cost shares for both Preferred Providers and In-Network Providers apply to the In-Network out-of-pocket maximum.

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 (855) 330-1218

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 330-1218 (855) .

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՝ (855) 330-1218:

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(855) 330-1218。

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 330-1218 (855) تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 330-1218.

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Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(855) 330-1218로 문의하십시오.

Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (855) 330-1218.

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: (855) 330-1218.

Punjabi (ਪੰਜਾਬੀ): ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (855) 330-1218 ਤੇ ਕਾਲ ਕਰੋ।

Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (855) 330-1218.

Spanish (Español): Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (855) 330-1218.

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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 (855) 330-1218.

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