Your summary of benefits

Anthem BlueCross BlueShield

Your Plan: Anthem Silver PPO 2000/30%/4500 Plus

Your Network: Anthem 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 contract of coverage. If there is a difference between this summary and the contract of coverage, the contract of coverage will prevail.

Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Overall Deductible *This is an embedded deductible plan. See notes section at the end of the document to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Retail Prescription Drug Coverage section.*	Member: $2,000 For Family: $4,000	Member: $5,000 For Family: $10,000
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 at the end of the document for additional information regarding your out of pocket maximum.* *For prescription drug, all cost shares count towards your plan's annual out-of-pocket limit.*	Member: $4,500 For Family: $9,000	Member: $13,500 For Family: $27,000
Doctor Home and Office Services *Plan covers first 3 office visits (excluding preventive, maternity and urgent care) per member per benefit period at a copay and the 3 visits are combined across all office settings. This copay is before deductible and all subsequent office visits for the remainder of the benefit period, regardless of professional provider rendering care, are subject to applicable deductible and coinsurance.*		
Preventive care *In-network preventive care is not subject to deductible, if your plan has a deductible.*	Covered in full	50% coinsurance after deductible
Primary care visit to treat an injury or illness	$50 copay or 30% coinsurance after deductible	50% coinsurance after deductible
Specialist care visit	$50 copay or 30% coinsurance after deductible	50% coinsurance after deductible
Prenatal and postpartum care	30% coinsurance after deductible	50% coinsurance after deductible

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Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Doctor Home and Office Services (*continued*)		
Other practitioner visits:		
Retail health clinic	$50 copay or 30% coinsurance after deductible	50% coinsurance after deductible
On-line visit	$50 copay or 30% coinsurance after deductible	50% coinsurance after deductible
Manipulative therapy *Limited to 20 combined visits for Manipulative treatment, Acupuncture and Massage Therapy. Visit limit does not apply to osteopathic Manipulative treatment.*	$30 copay or 30% coinsurance after deductible	Not covered
Acupuncture *Limited to 20 combined visits for Manipulative treatment, Acupuncture and Massage Therapy.*	$30 copay or 30% coinsurance after deductible	Not covered
Other services in an office:		
Allergy testing	30% coinsurance after deductible	50% coinsurance after deductible
Chemo/radiation therapy	30% coinsurance after deductible	50% coinsurance after deductible
Hemodialysis	30% coinsurance after deductible	50% coinsurance after deductible
Prescription drugs	30% coinsurance after deductible	50% coinsurance after deductible

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Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Diagnostic Services		
Lab:		
Freestanding/Reference Labs	30% coinsurance after deductible	50% coinsurance after deductible
Office *Office cost share applies only when Freestanding/Reference lab is not used.*	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient hospital	30% coinsurance after deductible	50% coinsurance after deductible
X-ray:		
Office	30% coinsurance after deductible	50% coinsurance after deductible
Freestanding radiology center	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient hospital	30% coinsurance after deductible	50% coinsurance after deductible
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office	30% coinsurance after deductible	50% coinsurance after deductible
Freestanding radiology center	$250 copay and then 30% coinsurance after deductible	50% coinsurance after deductible
Outpatient hospital	$250 copay and then 30% coinsurance after deductible	50% coinsurance after deductible

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Covered Medical Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Emergency and Urgent Care		
Urgent care (office setting)	30% coinsurance after deductible	50% coinsurance after deductible
Emergency room facility services	$300 copay and then 30% coinsurance after deductible	Same as In Network
Emergency room doctor and other services	30% coinsurance after deductible	Same as In Network
Ambulance (air and ground)	30% coinsurance after deductible	Same as In Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit	$50 copay or 30% coinsurance after deductible	50% coinsurance after deductible
Facility visit:		
Facility fees	$250 copay and then 30% coinsurance after deductible	50% coinsurance after deductible
Doctor services	30% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery		
Facility fee:		
Freestanding surgical center	$300 copay and then 30% coinsurance after deductible	50% coinsurance after deductible
Hospital	$300 copay and then 30% coinsurance after deductible	50% coinsurance after deductible
Doctor services:		
Freestanding surgical center	30% coinsurance after deductible	50% coinsurance after deductible
Hospital	30% coinsurance after deductible	50% coinsurance after deductible

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Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse) **Facility fee (for example, room & board)**	$500 copay and then 30% coinsurance after deductible	50% coinsurance after deductible
Doctor and other services	30% coinsurance after deductible	50% coinsurance after deductible
Recovery & Rehabilitation **Home health care** *Limited to 28 hours per week, and in and out of network. Includes Private Duty Nursing in the home. Limit does not apply to Physical, Occupational or Speech Therapy when performed as part of Home Health nor to Home Infusion Therapy or Home Dialysis.*	30% coinsurance after deductible	50% coinsurance after deductible
Rehabilitation services **(for example, physical/speech/occupational therapy):** Office Outpatient hospital *Limited to 20 separate visits for rehabilitative services and an additional 20 separate visits for habilitative services. Visit limits are combined in and out of network, however, the visit limit does not apply when care is performed as part of Hospice.*	 $50 copay or 30% coinsurance after deductible 30% coinsurance after deductible	 50% coinsurance after deductible 50% coinsurance after deductible
Cardiac rehabilitation Office Outpatient hospital	 $50 copay or 30% coinsurance after deductible 30% coinsurance after deductible	 50% coinsurance after deductible 50% coinsurance after deductible
Skilled nursing care (in a facility) *Limited to 100 combined days for Outpatient Rehabilitation and Skilled Nursing Facility services. Day limit is combined in and out of network.*	$500 copay and then 30% coinsurance after deductible	50% coinsurance after deductible
Durable medical equipment & prosthetics	30% coinsurance after deductible	50% coinsurance after deductible

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Covered Prescription Drug Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Retail Prescription Drug Coverage ***This plan uses a Select Drug List. Drugs not on the list are not covered.*** ***This plan includes Home Delivery (Mail Order), Home Delivery copays are 2.5 [Tier 1], 3.0 [Tier 2], 3.0 [Tier 3], 3.0 [Tier 4] times retail copays and select drugs are available for up to a 90 day supply.***		
Deductible *Your prescription drug deductible applies to Tiers [2] [3] [4] only,and is combined in-network and out-of-network if your plan includes out-of-network coverage.*	Prescription Deductible (Member) : $250 Prescription Deductible (Family) : $500	Prescription Deductible (Member) : $250 Prescription Deductible (Family) : $500
Drug tier 1 - Typically Generic	$15 copay	50% coinsurance
Drug tier 2 - Typically Preferred / Formulary Brand	$40 copay after deductible	50% coinsurance after deductible
Drug tier 3 - Typically Non-preferred/Non-formulary and Specialty Drugs	$80 copay after deductible	50% coinsurance after deductible
Drug tier 4 - Typically Specialty Drugs	$375 copay after deductible	50% coinsurance after deductible

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Covered Vision Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
This is a brief outline of your vision 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 vision services count towards your out of pocket limit.*	*Eye exams are covered once per benefit period. Eyeglass lenses and frames are covered once every other benefit period. Contact lens benefit is available only if the eyeglass lens benefit is not used. For children through age 18: There is a selection of frames and contact lenses that are covered under this plan. Review the formal contract of coverage or contact your vision provider for more information.*	*For covered services with a reimbursement amount, you will have no cost share up to that amount. All costs beyond the reimbursement amount are subject to balance billing.*
Children's Vision Essential Health Benefits		
Vision exam	$0 copay	$30 reimbursement
Frames	$0 copay	$45 reimbursement
Lenses		
Single	$0 copay	$25 reimbursement
Bifocal	$0 copay	$40 reimbursement
Trifocal	$0 copay	$55 reimbursement
Elective Contact Lenses	$0 copay	$60 reimbursement
Non-Elective Contact Lenses	$0 copay	$210 reimbursement

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Covered Vision Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-network Provider
Adult Vision Essential Health Benefits		
Vision exam	$20 copay	$30 reimbursement
Frames	$130 allowance	$45 reimbursement
Lenses		
Single	$20 copay	$25 reimbursement
Bifocal	$20 copay	$40 reimbursement
Trifocal	$20 copay	$55 reimbursement
Elective Contact Lenses	$80 allowance	$60 reimbursement
Non-Elective Contact Lenses	$0 copay	$210 reimbursement

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Covered Dental Benefits	Cost if you use an In-network Provider	Cost if you use an Out-of-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. *Children's dental services count towards your out of pocket limit.*		
Children's Dental Essential Health Benefits **Diagnostic and preventive**	10% coinsurance	30% coinsurance
Basic services	50% coinsurance after deductible	50% coinsurance after deductible
Major services	50% coinsurance after deductible	50% coinsurance after deductible
Medically Necessary Orthodontia services	50% coinsurance after deductible	50% coinsurance after deductible
Cosmetic Orthodontia services	Not covered	Not covered
Deductible (Applies to all services except diagnostic & preventive)	Combined with Medical	Combined with Medical
Out-of-Pocket Limit	Combined with Medical	Combined with Medical
Adult Dental Essential Health Benefits **Diagnostic and preventive**	Not covered	Not covered
Basic services	Not covered	Not covered
Major services	Not covered	Not covered
Deductible	Not covered	Not covered

Out-of-Pocket Limit	Not covered	Not covered

Your plan also includes the following Healthy Support & Rewards features		
Healthy Lifestyles Online with Well Being Assessment	Online well-being health improvement program focused on physical, social and emotional behaviors, including healthy eating, exercise and weight management	
Quarterly Health Webinars	One hour health education seminars delivered via the web	
Tobacco free certification with incentives	By certifying online, members are rewarded for being tobacco free	$50 / year gift card
Adult wellness exam	Members are rewarded for getting their annual adult wellness exam	$50 / year gift card
Annual flu shot	Members are rewarded for getting their annual flu shot	$50 / year gift card
Gym membership reimbursement	Members are rewarded for regular visits to their gym	Up to $400 / year
Healthy Lifestyles incentives	Members track rewards online for participating in Healthy Lifestyles	Up to $150 / year in gift cards

Notes:

- Your plan requires a selection of a Primary Care Physician.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to 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.
- Your copays, coinsurance and deductible count toward your out of pocket amount.
- If your plan includes a hospital stay copay and you are readmitted within 72 hours of a prior admission for the same diagnosis, your hospital stay copay for your readmission is waived.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- 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.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- For additional information on this plan, please visit sbc.anthem.com to obtain a "Summary of Benefit Coverage".